

2010

Living Sicker, Dying Younger: Health Care on Montana's Indian Reservations, 2010

University of Montana--Missoula. School of Journalism. Native News Honors Project

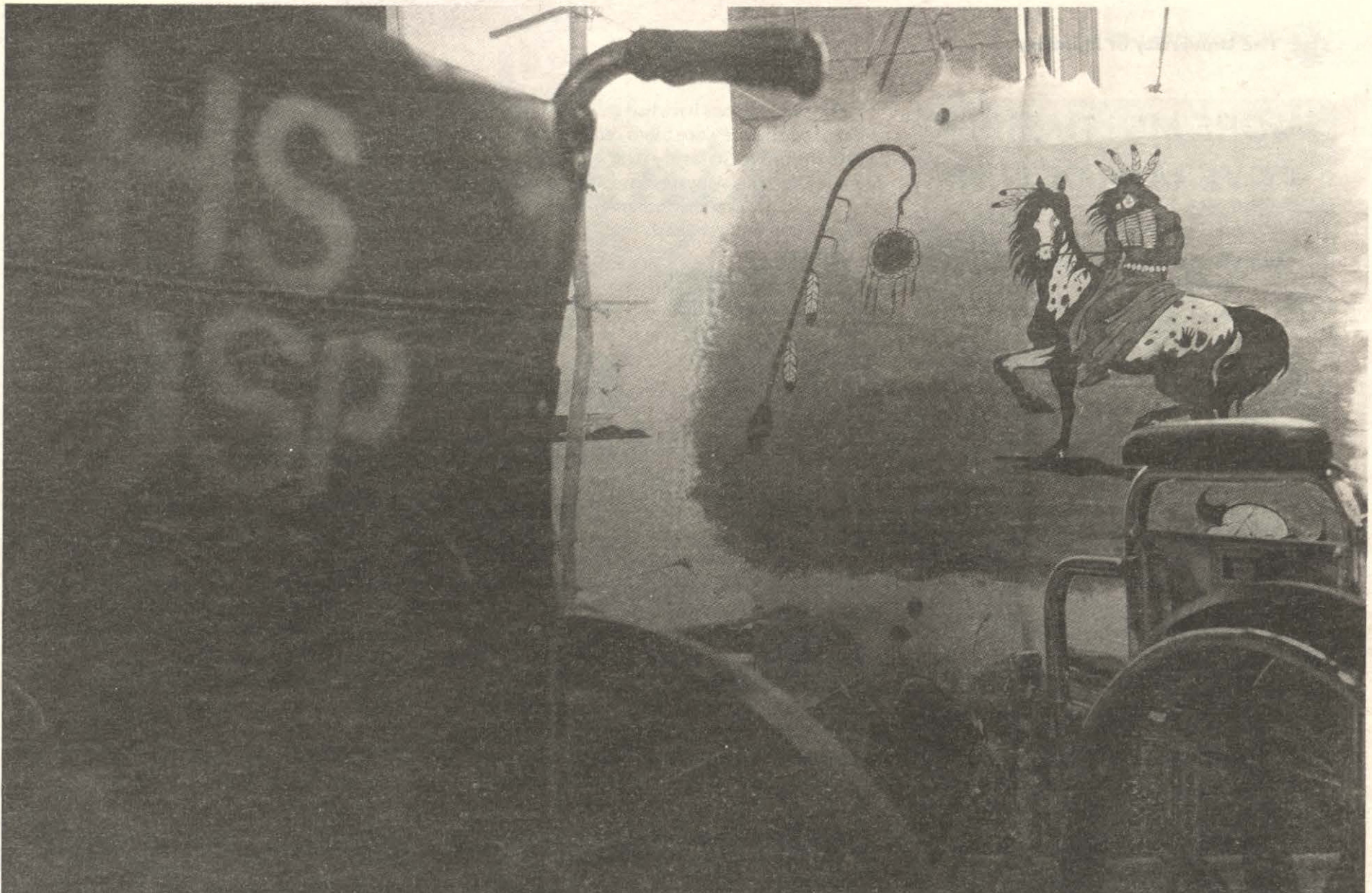
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Living Sicker, Dying Younger

Health Care on Montana's Indian Reservations

The University of Montana
School of Journalism • 2010

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COVER PHOTO by *Eric Oravsky*

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American Indians have had government-supplied health care since tribes ceded ancestral land to the United States in exchange for certain promised benefits. Why, then, are American Indians as a population sicker than other Americans and dying at much younger ages?

The American government's delivery on the promise of health care has had a rocky history. Responsibility over the centuries has shifted from the War Department to the Bureau of Indian Affairs to the Indian Health Service. Tribes themselves have shared oversight for health care since the Self-Determination and Education Assistance Act of 1975. Yet still the disparity in the health status of Americans remains.

Indians are 500 percent more likely to contract tuberculosis, 519 percent more likely to become alcoholics, and 195 percent more likely to develop diabetes. They also have a 149 percent higher rate of accidental injury, and are 72 percent more likely to commit suicide than the general population.

The reasons are both social and economic.

Poverty, access to care, social problems and a lack of funding to meet more than basic needs have compounded the health issues of this nation's first peoples.

The University of Montana School of Journalism's Native News Honors class examined

some issues that affect the health of Indians on the state's seven reservation and those enrolled tribal members who live away from the reservations.

In this issue you'll find stories that shed light on the cultural and physical distances that many Indians encounter when seeking health care, and others that examine the problems of

youth suicide, alcoholism and water sanitation. Other stories show the progress Montana tribes are making to heal their communities, such as implementing cultural advocacy groups and alcoholism treatment programs.

The stories are as varied as each Montana reservation and tribe. But, underneath them all is hope for a better future, and hope that, in time, the state's Indian tribes will regain the health and vigor that for centuries made them a resilient people.

The Promise of Health Care on Montana's Indian Reservations

Acknowledgements

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If you have comments about the project we'd like to hear from you. E-mail us at carol.vanvalkenburg@umontana.edu, or jeremy.lurgio@umontana.edu, or write to Native News Honors Project, School of Journalism, University of Montana, 32 Campus Drive, Missoula, MT 59812.

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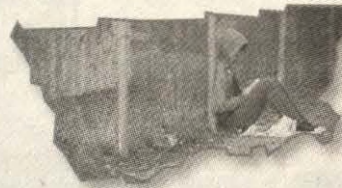
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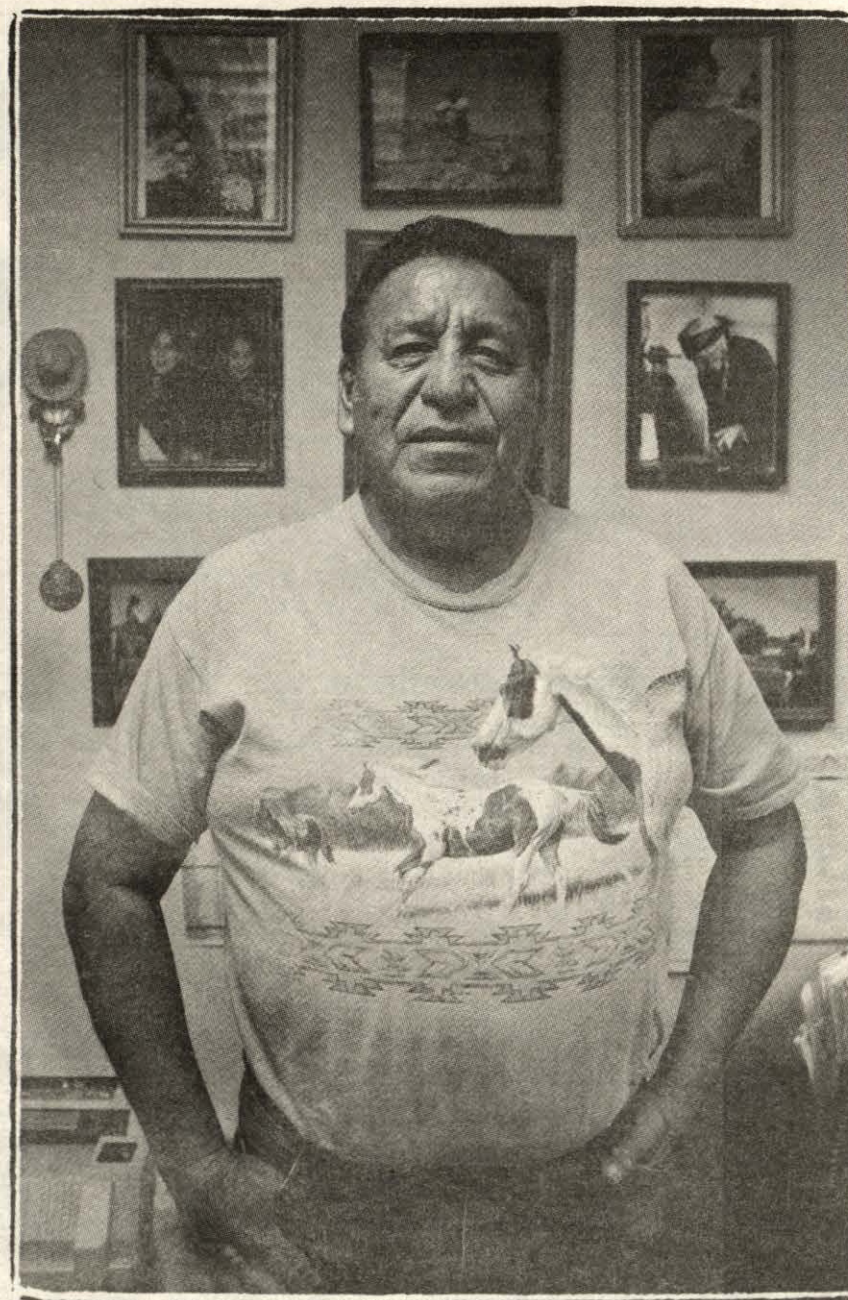
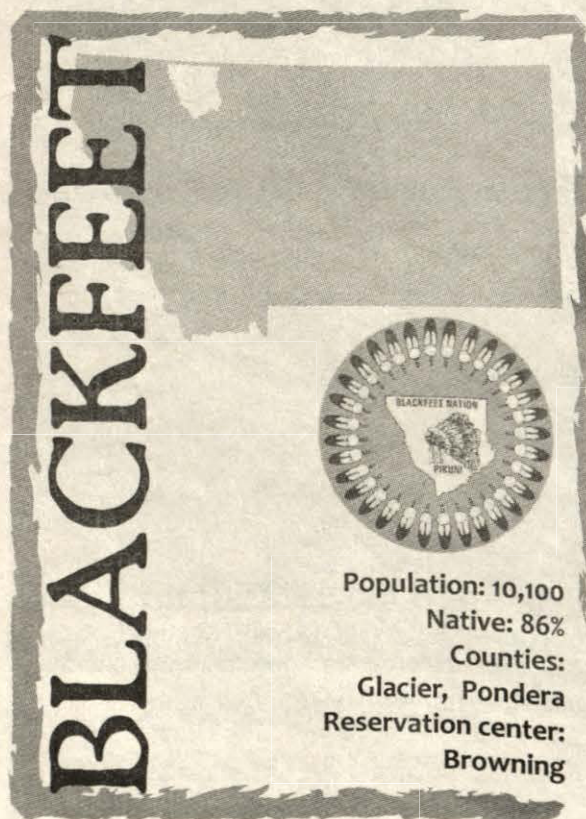
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Struggle for. Sobriety

*Written by
Roman Stubbs*

*Photography by
Charlie Baser*



From the roads, from behind buildings, from Ick's Place liquor store, they come. The street people of Browning emerge, hoods up, shields for an April wind that stings.

They walk toward the bright red Toyota Corolla, parked behind the liquor store. A woman waits there, standing next to a rubble of rocks, bent pipes and an empty vodka bottle.

Then Zita Bremner pops her trunk to share her lunch hour with them, just as she does on every Wednesday. They open their hands and Bremner squirts lime-green sanitizer into each pair. She reaches into her trunk with black cotton gloves and gives each person a brown paper bag with a hot

dog and granola tucked inside. Then she grabs the ladle from a steaming tin, and pours vegetable soup into Styrofoam cups.

Most of the people here are intoxicated, she says. Most cannot stand straight, most cannot talk straight. Of the 20 people she serves under the sun in Browning on this cold April afternoon, many ask for two bags and two cups of soup. These might be the Blackfeet Reservation's most downtrodden people, but they're Bremner's people too.

"For most of them, this is one of the only meals that they will eat this week," she says.

To the last woman she serves, she gives two bags and two cups, and instructs her to put the bags in her torn black Oakland Raider's coat, and to be careful with the hot vegetable broth.

Before the woman wearily walks away, she asks a question that has been often repeated from the hungry people today: Where is Sandra?

The question is only a small moment but serves to reinforce the significance of Sandra Calf Boss Ribs' deeds and spirit in the parking lot behind Ick's Place, where the pavement glistens with glass shrapnel. Every Wednesday for a year, Calf Boss Ribs has taken a half-hour lunch break from her job as a counselor at the Crystal Creek Lodge Treatment Center and made the three-minute drive to Ick's to deliver promise to their lives, stock to their stomachs.

On the day Browning's hungry yearn for her, Calf Boss Ribs is in Great Falls on business representing the Crystal Creek Lodge, but she is also there to lobby the local food bank for additional aid in order to expand her project — which has grown to include volunteers helping serve on Mondays and Saturdays.

Estimates in this Blackfeet town of 3,500 souls are that at least one in three suffers from alcohol and drug addiction, and 70 percent are unemployed. If only there was more room at the Crystal Creek Lodge.

...

In 1994, Sandra Calf Boss Ribs underwent treatment for substance abuse at the Crystal Creek Lodge. She battled her addiction for more than 30 days that fall and stayed past her treatment period so that she could help cook Thanksgiving dinner.

For Calf Boss Ribs, it wasn't the treatment that guided her to this field of substance abuse

counseling. It was the recognition of the two distinct spheres that exist on the Blackfeet Reservation: the environment in which residents are engulfed in alcohol, and the environment in which folks find the gumption to help. Calf Boss Ribs has been at Crystal Creek for seven years, and is the unit tech supervisor for the in-house patients. She is a professed "24-7" employee.

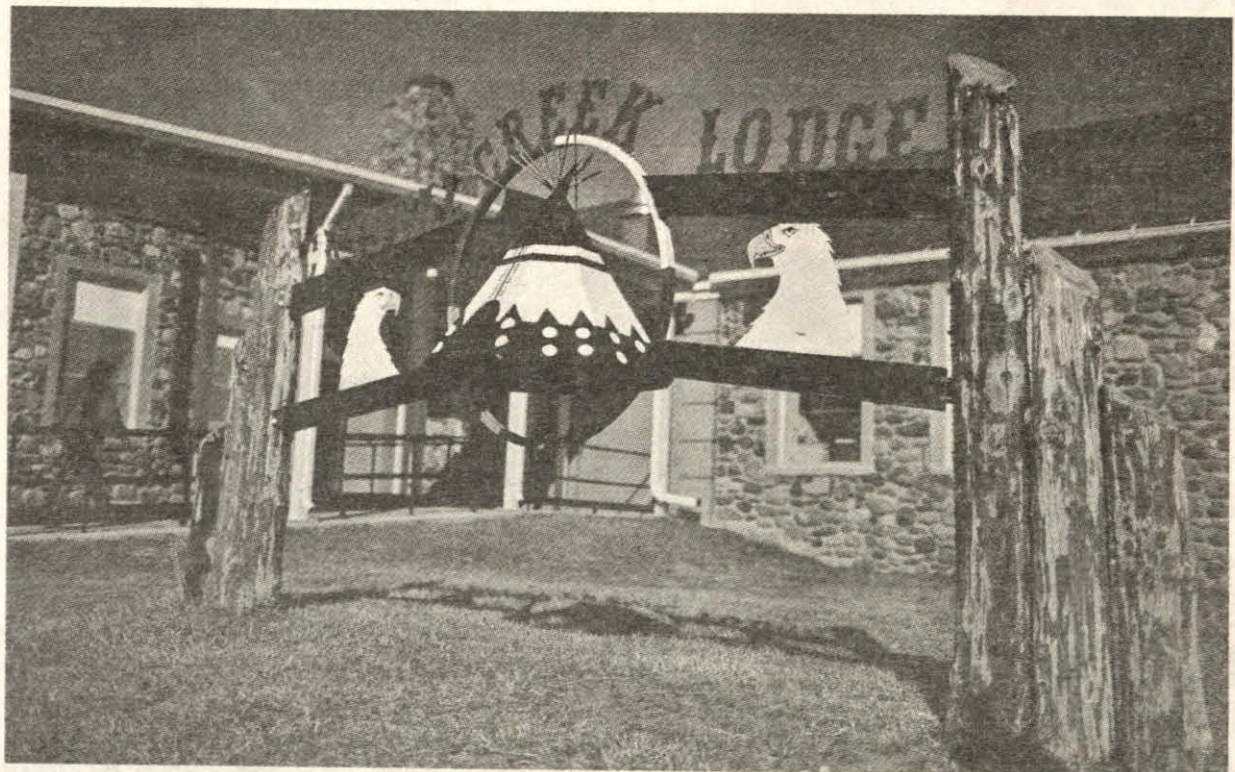
There were numerous treatment centers on the reservation 15 years ago: the Margie Kennedy Center, the Pikuni Family Healing Center for women and children, and a halfway house in Heart Butte, where Calf Boss Ribs began her career as an addiction counselor. By 2005, all three had succumbed to a lack of funds.

Only the Crystal Creek Lodge remains. It is the only accredited Native American substance abuse treatment center in Montana, serving members of all seven reservations and annually treating a small number of West Coast Indians from as far away as California.

Crystal Creek resides in the old Browning hospital building, an ancient and diminutive facility compared to the modern Blackfeet Community

Hospital abutting it. A wing connects the two buildings; patients must undergo detoxification at the IHS-run hospital before being transplanted down the hallway into the Crystal Creek Lodge. Detox is the most grueling part of the process, normally a three-day stint during which patients are hooked to "banana bags," IV's full of nutrients to neutralize alcohol and narcotics if necessary, and to restore the body's chemical balance. In recent years, opiate and narcotic abuse has spiked on the reservation and the personnel at Crystal Creek say these patients are often more volatile than alcoholics, who comprise 77 percent of their clientele.

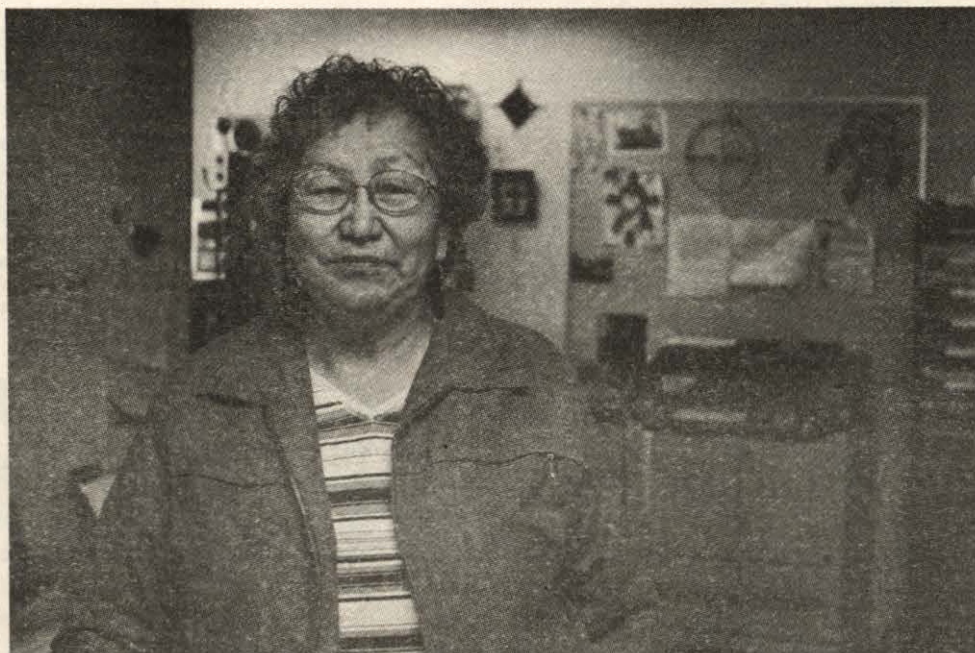
The treatment center operates much like a disciplined academy: patients are up and showered by 6:30 a.m., and breakfast, meditation and chores occur every morning. There are morning and afternoon lectures, on topics ranging from gender to culture to anger management. Every night at 7, alcohol and narcotics anonymous groups meet, and before bed, patients work on assigned reading and writing from the day's lectures. There are walks outside the facility every night, there are visits



LEFT: Herman Whitegrass, a recovering alcoholic and drug addict, is one of many former addicts who have turned their lives around and become staff members and counselors at the Crystal Creek Lodge in Browning.

ABOVE: Crystal Creek Lodge is the only certified alcohol and drug addiction treatment center in Montana specifically for Native Americans.

Counselor Sandra Calf Boss Ribs, herself a former patient, works at Crystal Creek Lodge to fight substance abuse on the reservation. She perseveres despite what she says is an abysmally low rate of success.



every week. Patients, walk out due to the

be contacted. Eight reported staying sober.

A long list of Blackfeet await admission to the 17-bed Crystal Creek Lodge, which is legally bound to treat court-ordered patients first. Last year, 44 patients checked themselves into treatment, while judges sent 34 to the lodge as part of sentencing.

It is that ratio that renders the struggle of Crystal Creek so difficult: it is a small facility and can only provide services to a small number of those who need them. The \$1.3 million the federal government spends to keep the lodge running dictates the number of beds. In February, when two

officials from the Commission on Accreditation of Rehabilitation Facilities inspected the facility and its practices, Crystal Creek Lodge received a new three-year accreditation. But the officials recommended Crystal Creek maintain its level of service, rather than expand it.

Other Montana reservations like the Crow and Northern Cheyenne have tried to combat alcohol abuse by banning the substance, but prohibition has proved nearly impossible to enforce and the \$50 fine the tribes levy against those who violate the law does little to discourage drinking.

The Blackfeet will, in all likelihood, never become an alcohol-free reservation, though that's occasionally been proposed. And without halfway houses and transitional centers for patients to ease back into the community, Crystal Creek counselors say, the task of staying sober remains a ruthless one.

"We serve a lot of people here," says Crystal Creek director Pat Calf Looking. "But if they go back to an environment where people are still using, it's really difficult for them."

More than 30 employees work at Crystal Creek and with a few exceptions, all have had bouts with alcohol and drug abuse. That includes Calf Looking, a former Marine who found work in the rehabilitation field after working as a bartender and bar manager and losing several wars inside treatment centers before becoming sober. He still considers himself an addict, but the rehabilitation service has become his life's calling. He is also working as a consultant to the Wyoming-Montana Tribal Leaders Council to erect a treatment center in Sheridan, Wyo.

Four employees of the lodge have been through treatment at Crystal Creek, and Calf Looking has established a strict zero-tolerance drug and alcohol policy. This winter he fired an employee who failed a drug test. For counselors and patients alike, staying sober is a constant struggle.

...

The lodge's greatest liability is having former addicts run its program. But it is also its greatest advantage. And even among the workers at Crystal Creek, there are horrific addiction stories.

When Herman Whitegrass sits potential patients down in his office, he can read if they are serious about getting clean or sober. He knows



need of aid frequent the alley behind Ick's Place in Browning. Crystal Creek Ribs distributes lunches to them every afternoon.



because he's been there.

Much of his addictive past sits on the 35-mile stretch of Highway 2 that leads out of Browning and snakes through the hills to Cut Bank. White Grass says he often drives that road, but never with his mind free of the possibilities.

"It's just like a gun pointing straight at you," he says. "A car that's coming in your direction, I always think, I hope that this person isn't drunk or drugged up or isn't suicidal, saying, 'The next car I'm taking somebody with me and I'm going to do myself in.' That's a reality."

The 68-year-old Whitegrass used to do it, used to drive that stretch as a young man drunk, telling his friends that if he had to die that he was going to take someone with him. They would all laugh at him.

Before he became one of Crystal Creek Lodge's longest tenured and most respected cultural healing leaders, he was elbow deep into addiction. It started one summer day in Browning, when he was 8 or 9 and working a fencing job on the prairie with his brother. They forgot their water jug and an older worker shared his six-pack of beer with them.

It followed him to the jungles of Vietnam, where he was deployed with the Army in 1965. It followed him back to Browning, where for a decade he considered himself one of Browning's street people, living on bedroom floors and, when it was warm enough, in abandoned cars. Beer, weed, cocaine, sometimes he says he didn't know what he was on. What he did know was that he was enraged from psychological problems that descended on him during his tour of Vietnam.

In 1979, after countless attempts at recovery in rehab centers in Wyoming and Canada, Whitegrass found volunteer work at the Medicine Pine Lodge in his native Browning under Margie Kennedy, a tough customer who ran Browning's detoxification unit throughout that era. His cravings were relentless for five or six years, but White Grass says that his purification came from spiritual healing from the elders of the Blackfeet Tribe.

At the Crystal Creek Lodge, where Whitegrass has served as an in-patient counselor for a quarter century, he uses his own life experiences to educate his patients. He speaks to families about his former street life and how he will always be an addict, even though he hasn't drank or drugged in nearly three decades.

"I attempt to teach people that recovery goes

on for a lifetime," Whitegrass says. "It goes on until you die. We can't make you stop drinking, but we can show you how it's done."

All these years later, it still follows him. He is a big man, with linebacker shoulders, a belly and a clear complexion. He has diabetes, high blood pressure and heart problems. His daughter Amy is in jail in California due to what he says are alcohol and drug-related problems, and he is raising her 4-year-old son in Browning.

He lost his son Shawn to alcoholism in February 2008.

Whitegrass didn't know his 36-year old son had a drinking problem. And by the time he got on Highway 2 and made his way along Interstate 15 toward the hospital in Great Falls, Shawn was in a coma. A week later he was gone.

...

Behind the steel doors, deep in the bowels of Crystal Creek Lodge, the patients rest late on a Friday afternoon.

The menacing uncertainties that face the program's future — the questions of funding, efficiency, and halfway houses — are muted today. Some women lie in their dorm rooms, while across the hallway in a run-down conference room, the aroma from a traditional smudge ceremony still lingers.

A group of five young men sits in the foyer

down the hall, playing Jenga. Sandra Calf Boss Ribs watches them from her desk.

She was there 16 years ago. They all have different reasons for being here, Calf Boss Ribs, Calf Looking, Whitegrass. If Calf Boss Ribs' wild guess is correct, that only 2 percent of the patients remain sober after leaving the facility in Browning, then it's that 2 percent that keeps the Crystal Creek Lodge going. The lodge's workers see earlier versions of themselves in the patients. That's why Whitegrass tells families of patients his story of resilience, why Calf Looking is helping to establish a treatment center in Wyoming. It's why Calf Boss Ribs started the lunch program in the parking lot behind Ick's, and has inspired people like Zita Bremner to help her.

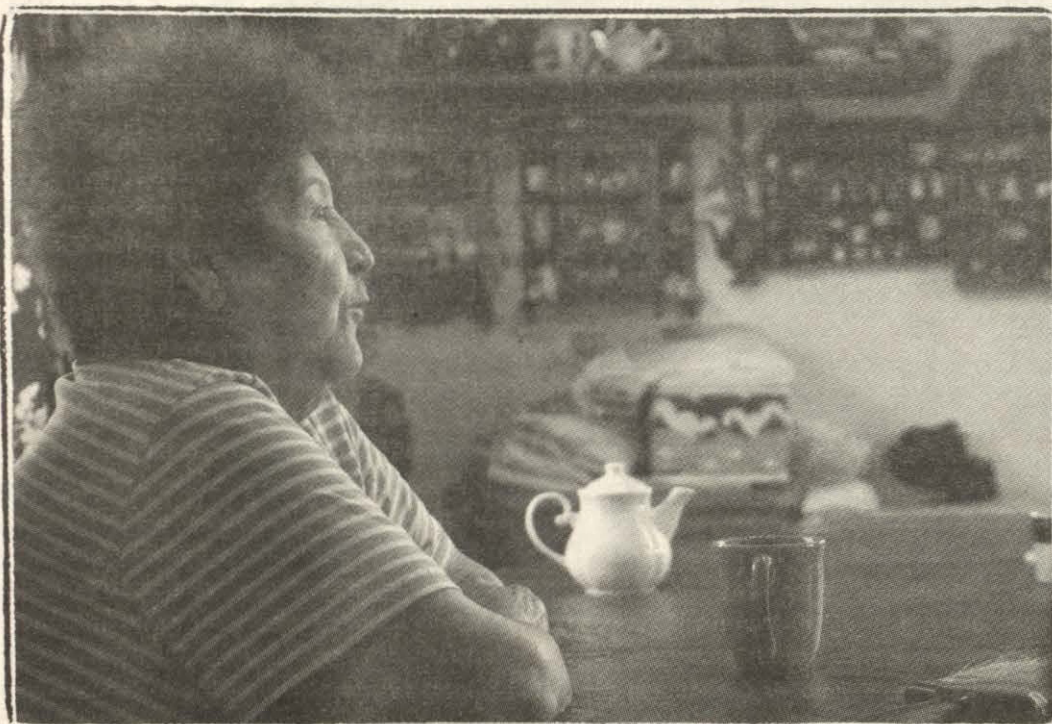
The patients are allowed a trip to one Alcoholics Anonymous meeting outside the facility per week, and this week it's in Cut Bank, where the patients will get pizza before their meeting. Outside, a white van backs up near the Crystal Creek Lodge. Soon the patients will board, then head down the highway to Cut Bank.

The Jenga tower collapses on the table and the patients yell and laugh. There is a contentedness in the room, maybe because this is one of the safest, securest Friday nights that one could have on the Blackfeet Reservation.

"I know what their needs are, I see what their needs are," says Calf Boss Ribs. "I can see it from both sides."



Whitegrass meets with other counselors at Crystal Creek Lodge. Whitegrass deeply believes his experience as an addict makes him a better counselor to those in recovery.



Elsie Geboe says that the first thing her husband did after being diagnosed with stage-four lung cancer was smoke two cigarettes. Geboe has cervical cancer, but it is currently in remission.

Tobacco Roulette

*Written by
Erin Cole*

*Photography by
Alisia Duganz*

In the crevice of a pine-studded hill near her home, Luanne Belcourt pauses in the stiff spring wind to light a cigarette.

Instead of smoking, however, she takes a solitary puff and then places it upon the grave of her brother-in-law, Robert Geboe. To an outsider, this act might be viewed as a bizarre display of irony, as Robert died of lung cancer. But here on Rocky Boy's Reservation, this cigarette is a sacred offering.

Across the road, several curves deep into Parker Canyon near Rocky Boy Agency, a dirt lane loops in front of a small blue house. The address is Elsie's Circle, home to Robert's widow, Elsie.

Inside the home, after navigating through a gaggle of rambunctious children, one finds Elsie in the kitchen. A small, compact woman, Elsie radiates the warm smiles and personality of a beloved grandmother, which she is 27 times over. She bakes,

sews powwow costumes for her family and collects teapots. These vessels, of all shapes, sizes and colors, line one of the dining room walls. Elsie says she ought to dust her collection once a year, but at 70, she admits she isn't as spry as she once was.

Most of the teapots are gifts from friends and relatives and all of them would tell unique stories if they could speak. Her nephew, Donnie Belcourt, brought one back with him when he competed in the 1992 Olympic track trials in Louisiana. A faded orange one belonged to her mother, Celia, a Cree-speaking master beader. The last time Elsie counted, she nearly had 200, despite the actions of her carpenter husband a number of years ago.

"My husband put new siding on the house," Elsie says with a half smile as she sits at her kitchen table. "He was just pounding away and they were falling off the wall.

"I wasn't here. I came home from work and asked, 'What happened?' I gathered all the pieces and tried to glue them back together. Some I couldn't."

In 2004, Elsie was once again picking up shattered pieces. A mere 23 days after being diagnosed with lung cancer, her husband of 46

ROCKY BOY'S



Population: 3,500
Native: 98%
Counties:
Hill, Choteau
Reservation center:
Rocky Boy Agency

years passed away.

"Twenty three days," Elsie says the words slowly, as if they are still hard to believe. "We went to Great Falls and the doctor said, 'It seems like you're losing a lot of weight.' So they did all these tests and they said, 'You'd better stay, we're going to do some more tests,' and then they told him that he had cancer."

Although the cancer had spread from his lungs to his other organs and brain, the diagnosis didn't deter Robert, whom Elsie says often exhibited a stubborn streak, from lighting up his beloved unfiltered Pall Malls as soon as they started on the 100-mile-trip back home.

"When he got out of the hospital, he said, 'Where are my cigarettes? Give me two,'" Elsie says, holding her hands at chin level. "And he said, 'I'm going to put one in each hand.'"

Because Robert refused hospice care, Elsie quit her job at the tribal office to nurse him at home. Doctors gave him about six months to live. A man who had worn cowboy boots and Levi's every day for years now napped on the living room couch wearing pajamas and tennis shoes.

"He just got weaker every day," Elsie says of the man who once took morning jogs a mile around the circle. "Pretty soon he couldn't drive. He was here up until the day he died."

While the Lung Cancer Alliance rates lung cancer as the third-leading cause of death for American Indians, the statistics are even more dire for Montana's Indians. Indian Health Service statistics reveal that the Billings-area IHS, which includes Montana's seven reservations, has the highest lung cancer fatality rate of any IHS area in the nation.

Elsie, who also lost a daughter and a brother to cancer, was herself diagnosed with cervical cancer last year. After receiving treatment five hours away in Billings, she is cancer free, but her attitude is somber after witnessing her loved ones' deaths.

"No one tells me anything, if I have a week, a month, or a year," she says. "So I just wait and take each day at a time. Whatever will be, will be."

Many on Rocky Boy's share a similar attitude; that one's fate is fixed and therefore, the present day ought to be enjoyed to its fullest, health consequences be damned. When taking the tribe's turbulent history into context, this philosophy is more readily understood.

Rocky Boy's is a reservation that almost wasn't.

In 1896, when the state's other reservations had been long established, Congress appropriated \$5,000 to deport the "Canadian Cree" back to their ancestral home in Canada. Although they were transported across the border in boxcars, the tribe returned to north-central Montana, the only home the current generations had known. Once known as "the only people in the United States without a country," a 1916 congressional order finally gave the scattered and starving Chippewa Cree a sovereign home, a 55,000-acre reserve at the foot of the Bear Paw Mountains. Although the restoration of a



Luanne Belcourt places a lit cigarette on her brother-in-law Robert Geboe's grave. Tobacco is considered a sacred offering and a gift to loved ones who have died.

homeland was complete, the tribe had learned not to take anything for granted.

Today, no true town exists on the reservation. As the smallest of Montana's seven reservations, Rocky Boy's would fit comfortably inside Flathead Lake. Small clumps of houses and administration buildings appear along a network of curving roads. Vast fields, contained by fences choked with plastic bags and tumbleweeds, separate individual neighborhoods.

There are three places on Rocky Boy's to

purchase tobacco and all are within a five-minute drive of each other. In 2005, the reservation entered into a tobacco tax revenue sharing agreement with the state of Montana. This means that all tobacco products, whether sold to Indians or non-Indians, are taxed at the state's rate and the tribe receives an annual share of the profits, estimated to be around \$500,000.

The cash influx is a welcome benefit to this isolated tribe. Without abundant tourism or natural resources, many on the reservation struggle to eek out a living. However, the health problems that arise from this tobacco income are crippling the older generation, who are often the primary caregivers for their grandchildren.

When visiting Rocky Boy's, it's impossible not to spot the men, women and teen smokers and chewers who are making the lung cancer statistic a reality. People congregate outside their places of work to take smoke breaks. Scattered cigarette butts are a common sight outside of building entryways.

Yet, when asked if they know of someone struggling with the disease, people wryly smile at their own cigarettes and shake their heads. The grim reality is that with its difficult, and often late diagnosis, few lung cancer patients survive to see their illness fade into remission. Their deaths help shadow the problem into oblivion.

Until Columbus stumbled upon the New World in the 15th century, tobacco was unknown to Western civilization. Originally grown in South and Central America, the tobacco plant migrated north through trade and agriculture. Ancestors of today's Chippewa Cree traded fur pelts for it from southern tribes and the Hudson Bay Co.

To the Chippewa Cree, tobacco has a spiritual symbolism. The lighting of the ceremonial pipe is an act of a solemn ritual that is absent when taking a drag off a recreational cigarette. The tribe believes that pipe smoke carries their prayers to the Creator, and that for tribal members seeking knowledge, a gift of tobacco is always appropriate. Those who inhale concede that tobacco smoke might possibly cause cancer, but believe it is a part of the culture that cannot be ignored.

"Tobacco was a sacred plant given to us by the Creator," says Lisa Whitford, a Rocky Boy's native who once served as the reservation's tobacco prevention coordinator. "The plant was taken when the white settlers came and added additives." ▶



Three places on the Rocky Boy's reservation sell cigarettes. Tax revenue from these sales goes to the tribe.

When Helen Stamper was a child, tobacco was sacred, using it in traditional ways. But as a Cree, she found a paradox when it comes to balancing their traditional uses of tobacco with the cancer sticks of the commercial age.

Rick Sunchild, who teaches Cree language at Rocky Boy High School, notes there exists a distinct difference between traditional tobaccos, both in how they are used and how they are made. "Tobacco was during the time when people made it using pipes," Sunchild says. "It was not really addictive."

Sunchild says the Chippewa Cree traditionally mix tobacco with other herbs and create a resulting product, which they call "muck," meaning "that which is mixed," or "mixture." This mixture is used in its traditional ways, but it is not in its traditional ways that it is used in the 1990s. In 1996, other than the traditional ways, the Windy Boy

Stamper wanted to go on a mission of last year, she finally went through the mission once planned, Helen was

airlifted from the helipad at Rocky Boy's to Benefis Hospital in Great Falls.

Earlier in the day, a recurring back pain had kept her from going in to work at the library at Stone Child College. Although Helen dreaded visits to the doctor, and hadn't had a checkup since she'd suffered from pneumonia two years earlier, the pain was severe enough to persuade her to drive to the reservation's health clinic.

"I remember having that backache for several months, maybe a year," she says.

Doctors initially suspected a heart issue when she mentioned the shooting pain she was also experiencing in her left arm. Because that would demand

more attention than the rural clinic could give, a helicopter was ordered.

For five days in Great Falls, Helen endured a gamut of blood tests, X-rays, MRIs, CAT scans and finally a PET scan before doctors broke the news: Helen had an advanced Pancoast tumor, one of the rarest forms of lung cancer. Unlike most lung cancer tumors that develop in the lower lungs, Pancoast tumors grow in the upper region and affect only 5 percent of all lung cancer patients.

"After they did that PET scan, (the oncologist) sat down with me and my family members," Helen says. "He gave me the options and said you can think about it."

Although she knew treatment would be costly and draining, both physically and emotionally to both her and her family, Helen chose to fight.

"I hate statistics," she says, her articulate voice growing in strength. "I don't like to think of myself, or anybody else, for that matter, as a number. I'm not a statistic, I'm a human being, so if the statistics say one thing I'm going to try to buck the system and be something else."

While she decided to entrust her body to modern medicine, Helen chose to put her faith in the traditional spiritual ways of her people. A Cree medicine man from Canada came to Rocky Boy's to perform a healing ceremony for her the weekend before she began treatment.



Helen Stamper Windy Boy lines up the medication she takes for her cancer treatment. She was diagnosed with stage-three lung cancer in August.

She took a leave of absence from her job to endure six weeks of chemo and radiation before undergoing surgery to remove the tumor. The surgery lasted eight hours, six hours longer than expected, and involved the removal of two upper ribs, one third of Helen's left lung and a nerve cluster, which was the source of her back pain.

While Helen had experienced minimal discomfort from her chemo and radiation, the surgery pushed her body to its limits. As a result of nerve damage from the operation, Helen finds herself in daily pain, a pain that she says is on par with what she experienced when she first went to the clinic in August. A daily dose of morphine and Vicodin does little to ease her discomfort.

"I deal with it every minute, but you know what? I'm alive," she says, tapping her fingers on a blue mug of coffee. "Without the treatment I went through, I might not be."

Helen is not naïve about what landed her on the surgery table last November. The denial she once had about her former tobacco habit has been replaced with a strong conviction.

"I smoked off and on for 40 years," she says. "If there was anything I'd do different it would be not to smoke, because I'm pretty convinced that that's what caused lung cancer."

Although she didn't realize it at the time, Helen smoked her last cigarette on the day of her helicopter ride. Nicotine patches, which helped her fight subsequent cravings, were paid for out-of-pocket. Meanwhile, Helen, who doesn't have health insurance, doesn't know how much her hospital bills total. Envelopes arrive in the mail, but most remain sealed, helping to distill the dread of knowing the full amount.

"I opened one of them one day and it was \$67,000," she says. "Ever since then, I haven't opened them."

These envelopes can be found throughout the house she rents from her nephew, mixed in with Wall Street Journals, and piled on a desk. Helen picks one up and notes that it bears a muddy stamp from the shoe of one of the three grandchildren who live with her. Trying to stay positive, she ignores the bills, but collection notices have started arriving, adding to her cancer's paper trail.

"They're not getting paid," Helen says, "but I know eventually they will. From my experiences in the past with contract health, is that it takes them time."

Her husband, Andrew, drops off the bills at the health clinic on Rocky Boy's when he goes to work. The envelopes end up in the hands of Carole Henderson, who manages the tribe's contract health services.

Henderson is one of many access points to a bureaucratic chain that stems from a promise the U.S. government made to provide health care to Native Americans in exchange for their lands. Henderson works in a basement office at the health clinic, accessed through a maze of beige-painted hallways. It is up to her and another woman to sort through the medical contract bills and see that they get paid.

"There's never enough money," Henderson says, sighing as she leans back in her desk chair. Multicolored sticky notes adorn a bulletin board at her side, signaling the paperwork and deadlines she faces.

Because modern cancer treatment is nonexistent on the reservation, patients suffering from lung cancer must travel to Great Falls for their surgery, radiation and chemo. This journey adds hotel, gas and meal tabs to the total bill, some of which is picked up by a tribal transportation office.

Rocky Boy's is one of Montana's reservations that operates its own health care system. Although the tribe receives IHS funding, it controls and operates tribal health services without IHS's daily oversight. While tribal leaders prefer this system to being run by IHS, the tribe faces difficulties in finding enough funding to ensure proper medical care for all tribal members. In 2006, the tribe borrowed \$2.8 million from the Denver-based Native American Bank to cover a shortfall in contract health care. They pledged future earnings from their tobacco tax revenue to secure the loan.

It is another moment rich in irony. Essentially the tribe is taking care of its sick from money it makes off a product that makes its people sick.

Although health care on Rocky Boy's has come a long way since the Depression—when a Havre doctor would drive 25 miles to visit the reservation once a month—to boasting a \$13 million clinic, it remains an imperfect system. Wide holes exist in the cancer screening process, and many people slip through.

Three years ago, the reservation's clinic was given a machine that uses computer technology to help radiologists detect lung cancer. But this addresses solely the symptoms of the problem and

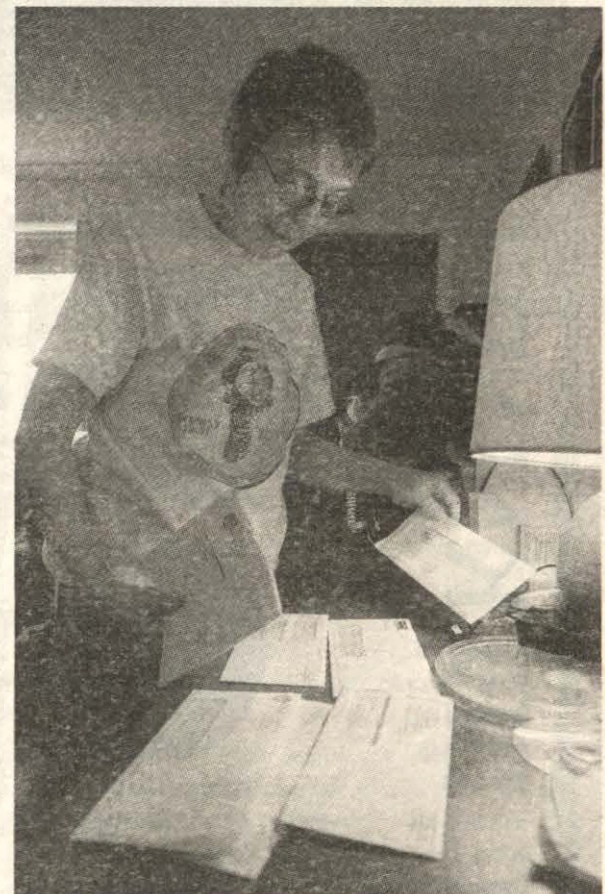
not the cause.

Only a systematic change will be enough to reverse the statistics; statistics, as noted by Helen Windy Boy, that stand for real human beings, and not meaningless numbers. These statistics represent the lives and deaths of Robert Geboe and countless others who gambled and lost on tobacco roulette.

Judi Houle is one tribal member who smokes, but doesn't let it worry her.

"I'm healthy," maintains Houle, who works at the Rocky Boy's Senior Citizen Center, a lofty building that smells of cake and cigarettes. Houle, both a grandmother and a long-time smoker, believes that genetics play a part in determining who will get sick from cancer.

Although Houle appears to be a healthy woman of middle age, a sharp cough interrupts her train of thought and rattles her dangling feather earrings.



Helen Stamper Windy Boy sorts through unopened medical bills. The tribal health service has yet to pay thousands of dollars in bills that have accrued.




Not a Drop to Drink

*Written by
Kimball Bennion*

*Photography by
Greta Rybus*

FT. BELKNAP



Population: 3,115
Native: 94%
Counties:
Blaine, Phillips
Reservation center:
Fort Belknap Agency

The vomit was yellow and foamy and it came up all the time. Arvilla Crasco had been sick before, but never like this.

She called them attacks. This one, at the bingo hall, didn't come with the warning of nausea. One second she was filling in her card at the table, the next she felt it coming up. She took a short gasp and lunged for the nearest trash can. In front of her friends, people she knew, she gagged and heaved the bitter bile and foam. Foam. Because her stomach didn't have anything left for her to expel.

It had to be *H. pylori*. Everyone on the Fort Belknap Indian Reservation in north central Montana knows someone who has it. Crasco does. Her niece has it, and a neighbor just on the other side of her house does too.

So does an estimated one-third of the U.S. population, but most who contract it will not have any symptoms. In any other place, a bacterium like *H. pylori* won't likely be the topic of discussion at a local bingo hall. In any other place, at the mere mention of its name, people won't be able to list the friends and family members they know who have gotten *H. pylori*.

Little data exists about *H. pylori* infection in the United States. Even less is known about infection on Fort Belknap, a 675,000-acre reservation located

along Montana's northern tier. So it's hard to tell exactly whether *H. pylori* infection is higher on Fort Belknap than in other places in the state. It's even harder to tell where it comes from.

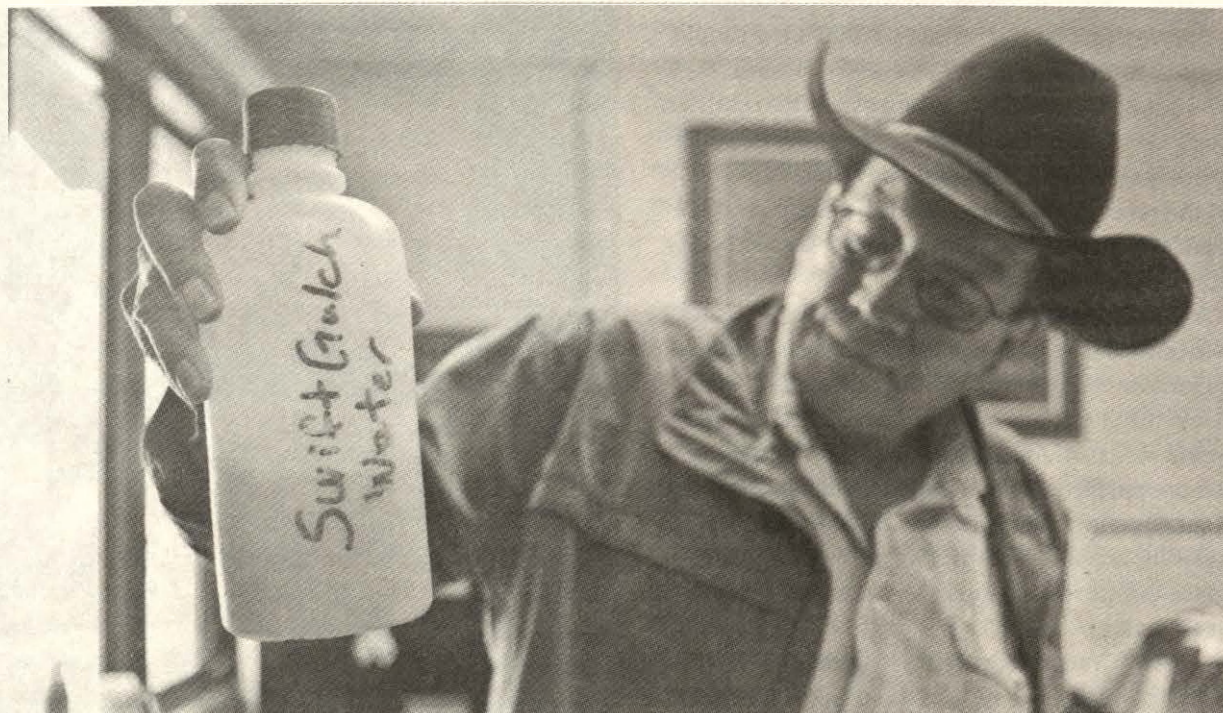
For Arvilla Crasco, the answer is right outside her window. She can look out and see a water tank that towers over the one-story homes in her neighborhood. For her, she says it's why she can't eat red meat without retching it back up anymore. For her, the water is why she hasn't felt like herself since 2003, when she was officially diagnosed with having *H. pylori*. For her, it's the reason she can't get out of bed some mornings, and missed so many days working for the tribal housing department, she says, that she eventually decided to quit. For her, it's why she'll still get the occasional attack after slipping a little and eating half of a burrito.

"I wouldn't wish this on anybody," she says. "You really get depressed. You get tired of feeling sick all the time."

A lot of people on Fort Belknap are tired. They're tired of water problems on the reservation and tired of the water woes inflicted on them. On the southern edge of the reservation, Swift Gulch runs red from pollution caused by the now bankrupt Zortman-Landusky gold mine in the Little Rocky Mountains. Up north, in the Agency, the murky water from the Milk River flowed for years into a dilapidated treatment plant that couldn't keep up with the demands of a growing population or with the changing standards of the Environmental Protection Agency. For about five years, the EPA has maintained a regular boil order for Fort Belknap, a warning to boil the tap water before drinking or cooking with it because of an unsafe level of bacteria.

Meanwhile, people like Crasco get sick, and they deem it only fair to point their fingers at the water. People have gotten sick before, one water source has been polluted before, and the EPA has been telling people to stay away from the Agency's tap water for about half a decade – those are the facts. Beyond that, the relationship between water and public health on this reservation exists solely in how people choose to perceive it. And that's where the waters really get poisoned.

H. pylori is short for a bacteria called *Helicobacter pylori*. Infection can cause any number of stomach problems, ranging from dyspepsia, ulcers or, in rare cases, lead to stomach cancer. But in most cases, it doesn't do much of anything. The



ABOVE: Tracy King, president of the Fort Belknap Indian Community Council, displays a sample taken from Swift Gulch. The creek running through the gulch gets its red coloration from runoff from the Zortman-Landusky gold mine on the southeast edge of the reservation.

OPPOSITE: A young girl helps her family collect water at the Snake Butte spring. Many reservation residents don't trust the purity of the water piped into their homes and choose spring water instead.

only way to know whether someone has it is to test for it specifically. But since many people infected with it don't show symptoms, it usually goes unnoticed.

Not in Fort Belknap, however.

Gregory Zaar, the chief medical officer for the Indian Health Service clinic at Fort Belknap Agency, says that although he sees only a few patients complaining of stomach problems, "the rumor mill is rampant."

For Zaar, the reality exists in the data, and since it would take a significant number of stomach illness cases to attract the type of comprehensive study needed to examine *H. pylori* on the reservation, the only data he can rely on is in what he's seen.

"I don't think that there is a problem," he says. But Zaar doesn't discount the perception of one.

Don Thomas, a physician who works in the Eagle Child Health Center in Hays, a town on the southern end of the reservation, says perception can have a lot to do with even the number of documented *H. Pylori* cases on the reservation.

"It's looked for very frequently, and so it's found very frequently," he says.

Thomas operates in Hays, where unlike in the

Agency, efforts for an updated treatment plant are further on the horizon. For now, even though he has no reason to say that cases of *H. pylori* are higher on Fort Belknap than anywhere else, he won't be drinking what comes from his tap anytime soon.

Whether *H. pylori* actually does come from the water is hard to pin down. The EPA lists 53 organic contaminants that it tests for in drinking water. The most usual culprit that the EPA finds after tests of the Agency's water are bacteria usually found in fecal matter, which doesn't rule out the possibility of *H. pylori*, but the EPA doesn't test for the bacteria specifically.

Studies do list municipal water contamination as one of the sources of infection, because it's most commonly passed from person to person, but a more likely cause relates to lower socioeconomic status and houses with many people living in close quarters. Both of those conditions exist on Fort Belknap, Thomas says. And after listing a host of other possibilities—food-borne infections, direct contact with fecal matter—Thomas eventually settles on the most common answer about this disease and its causes on Fort Belknap.

"We don't know," he says. "That's the simple answer to that question."

But not knowing is not an answer that satisfies many who live on this reservation. An Albertson's grocery store in Harlem, just a few miles outside of the reservation borders and a five-minute drive from Fort Belknap Agency, has made a commodity out of people's uncertainty.

Those uneasy about what's in their tap water will come here and load down their carts with five-gallon water jugs of store-bought water.

A filling station for water jugs sits at the front of the store, often causing congestion between the people filling up and the people checking out. A section of shelves in one aisle is devoted to different brands of bottled water, and any other space the store has left is usually devoted to cases of 20-ounce bottles.

When Tracy King was growing up, the only running water he knew was the creek. King is the president of the Fort Belknap Indian Community Council, the governing body of the reservation that represents the two tribes enrolled in Fort Belknap, the Assiniboine and the Gros Ventre. King grew up here, and remembers a childhood in the 1950s and '60s in which the only bathrooms he used were outhouses. By the 1970s, running water was a fairly new concept on Fort Belknap, and at about the same time, the Bureau of Indian Affairs decided to cede control of the water system to the tribal members. Fort Belknap's original water treatment



Arvilla Crasco adds bleach to her dishwater to kill any bacteria or contaminants that might be in the tap water. Arvilla was diagnosed with *H. pylori* in 2003, a type of bacteria that can cause acute stomach upsets.

plant was built shortly after that. According to King, the reservation's modern troubles with water began there.

"How do you make a decision when you don't

even know what toilet paper is?" King asks.

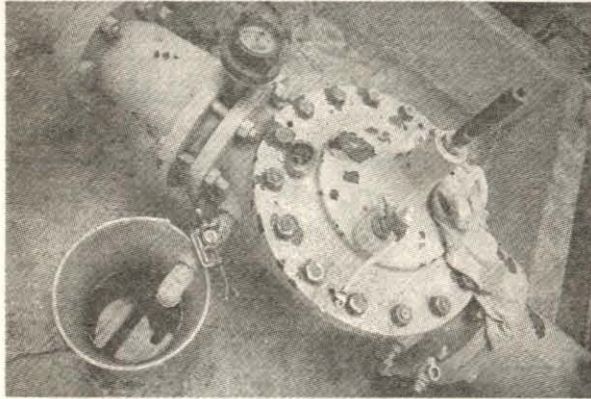
The original treatment plant soon became too old to keep up with the demands of the EPA, and too small to keep up with the demands of the reservation's growing population. One of the main functions of the treatment plant is to measure the water's turbidity, which is a measure of how clear the water is.

Murky water in itself doesn't necessarily mean it's unsafe to drink, but it can be an indication of bacterial contamination. The EPA has set turbidity standards for drinking water to prevent that. If the plant measures anything higher than those standards, operators must send a sample to a lab in Lewistown, where it will be tested for harmful bacteria to determine if a boil order should be issued. According to EPA standards, no more than 30 hours can pass between the lab request and the water analysis.

Under stricter EPA guidelines than in the past, more people to serve, and a fairly turbid water source to begin with, the plant has had no choice but to issue boil orders almost constantly since 2005.

A Fort Belknap resident buys clean water at the Albertson's grocery store in nearby Harlem. There is no grocery store on the reservation, so many residents travel the three miles from the reservation boundary to stock up.





Pipes pump in water from the Milk River for treatment at the plant. At left, the pipe system at the old plant. At right, a pipe in the newly built treatment plant.

That appears about to change. In late March, after almost a decade of trying to secure funding through government grants and loans, a brand new treatment plant opened up. It's bigger, uses better technology and depends more on automation. But after almost five years of constant EPA violations, regulators with the federal agency won't lift the current boil order until they see three straight months of operation without any violations. A rough road lies ahead in getting a mistrustful population on board with its new, and hopefully improved, tap water.

"I don't drink any water unless I know that it comes from a bottle," says Rowena Gone, who says she raised her children to never drink from the tap. Even though Gone has heard of the new plant and the possibility of clean water from the tap, she says she'll still avoid it. Three of her adult children have gotten sick in recent years, she says, and the only reason she knows is because they drank from the tap.

Gone buys water when she's pressed for time. Usually, like many others, she makes the 20-minute drive from the Agency to Snake Butte, where people can get free, clear water from a natural spring. For many, it's the best option. But even Snake Butte is plagued by its own list of unknowns. Gone, even though she continues to drink it, has heard rumors about nitrate in the water. Others talk about the possibility of arsenic. Some who have gotten a case of *H. pylori* say that it wasn't from the tap, but from Snake Butte.

Those rumors aren't stopping the succession of people who come, minutes apart, with five-gallon jugs in the backs of their vehicles, to fill up their water and take it home with them. It's natural, they say. It's ours. And that's enough for them.

At Snake Butte, the natural spring flows out through a long pipe that juts out of the stony flat-topped hill that overlooks the Agency. Clear, cold water streams from the pipe constantly, which is supported by two stone pillars that look almost like ancient altars—built to support a natural life source. Under the constant whisper of the water leaving the pipe and flowing into a tiny stream, there is a certain sacredness to what goes on here, here where the water flows clear. Not red. Not turbid. On the last stone pillar, five unlit cigarettes have been wedged on both sides where the pipe is secured to stone. A few quarters have been placed on whatever flat surfaces the pillar has. These are offerings, exchanges for the water that the people take to their homes.

But not all is sacred here. On the side of a



After filling several jugs of water at Snake Butte spring, George Tellstoomanystories leaves behind tobacco, in the form of a cigarette, as an offering of thanks.

flat rock, someone spray-painted the words, "No Dumping." And around the water, McDonald's wrappers, empty Bud Light tall boys and used plastic containers of hand sanitizer flout the message's intent. There is no pattern or deliberate placing of these artifacts.

For Fort Belknap, water is something to both cherish and deride. It's something that people will simultaneously revere as the source of life yet rue as something that diminishes it. A disease may not be epidemic, but confusion is.

Snake Butte's whisper is gradually drowned out by Kanye West's "Heartless" brimming out of the rolled up windows of a green midsize car.

George Tellstoomanystories and his buddy pull up to the spring and fetch a few five-gallon jugs out of the trunk. They're talking about water. How it's no good except for here at the spring and how his baby boy got sick from the tap water not too long ago. As he fills one of his jugs, it begins to leak. He curses and tosses the defective vessel on the ground where the water slowly leaks back into the spring. After filling up two good jugs, he has a smoke. Before he leaves, though, he breaks another cigarette in half and places it on the stone pillar.

Tellstoomanystories gets back in his car, and drives off with 10 more gallons of water that he'll be able to bring home. Kanye fades and the perpetual whisper of Snake Butte's natural spring can be heard again. On the ground, the leaky jug remains.

Long Road to Care



NORTHERN CHEYENNE



Population: 4,470
Native: 91%
Counties:
Rosebud, Big Horn
Reservation center:
Lame Deer

On the 14th second of every minute, the green punch clock on the wall of the Lame Deer Emergency Response Service's kitchen emits a pressurized snap.

Paramedic Sandy Bruised Head and on-duty dispatcher Karilyn Brady don't seem to notice it much as they play one of their countless games of Yahtzee. Fellow paramedic Charlee Prince looks on, resting her chin on a Diet Coke bottle. A black cordless phone sits off to the side of the game—silent, for now.

It's Friday night on the Northern Cheyenne Reservation, where about 4,500 Cheyenne live on

Written by
Steve Miller

Photography by
Adam Eschbach

land located about 100 miles east of Billings. It's the start of Easter weekend and a day after tribal payday, a combination that may well mean a busy night for the ambulances. Because the reservation prohibits alcohol sales or consumption, some reservation residents drive to one of the bars just beyond Northern Cheyenne borders, like the Kirby Saloon and Jimtown Bar. Judging by the number of crosses on the roadside between Lame Deer, the



heart of the reservation, and its outlying areas, this trip back from a night out can be short and brutal.

The EMS building—more of a trailer, really—is located a block away from Lame Deer's only stoplight. Its interior is lit by two panels of fluorescent lights, enough to illuminate the kitchen area while the rest of the main room remains in darkness. Bruised Head and Brady each grab a slice of banana bread on the stovetop as Prince goes into the dispatcher's room located past the TV and the L-shaped couch. Brady takes the dice and rolls two fours, a one, a five and a six.

Just after 8, the phone rings.

"Ambulance services," Brady says. She listens for a moment without making any movement, then quickly marches to the dispatcher's room, with Bruised Head on her heels. A 40-year-old woman named Vanessa is vomiting and having seizures. Vanessa lives in town, which won't be a long drive—at least compared to what this crew is used to. Prince walks down a dim corridor to a room where ambulance driver Maurice Little is sleeping.

"Come on," Prince says to Little. "Get those baby blues moving."

Prince, Bruised Head and Little pile into the ambulance and pull out onto Highway 212 for the three-minute trip to Vanessa's house. Inside, a young girl—Vanessa's granddaughter—stands in a dimly lit hallway, holding an Easter basket. Vanessa lies prostrate on a bed in a room with purple walls; her shoeless feet dangle off the bed. Her sister tells the paramedics Vanessa has been drinking whiskey and has snorted ground-up hydrocodone, a narcotic painkiller. Family members, including her granddaughter, filter into the room and watch with seemingly little emotion. Soon a seizure overtakes Vanessa. As she convulses, she lets out high-pitched, laughter-like gasps with each spasm.

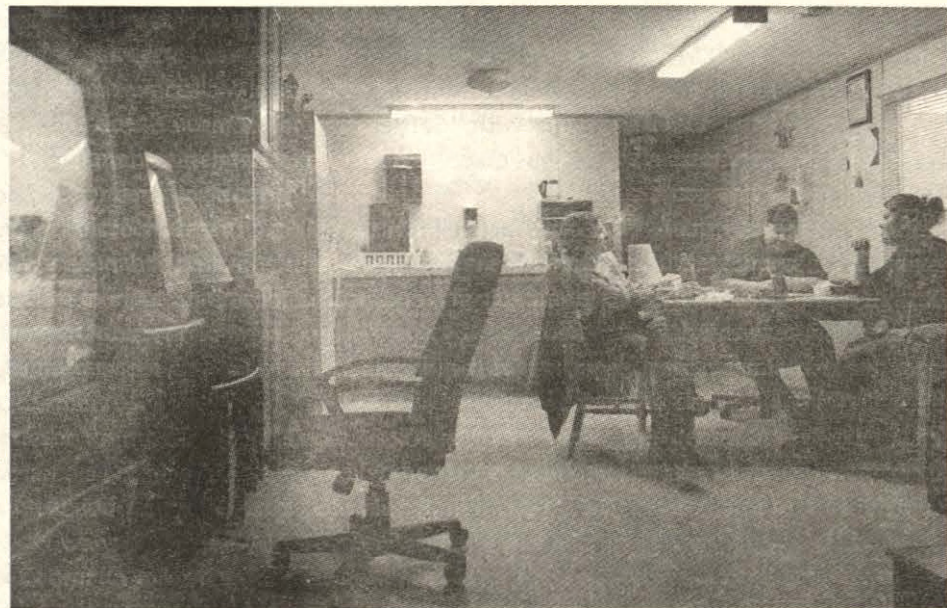
The paramedics transfer Vanessa from her bed to a gurney and into the ambulance, all the while holding a bucket for her. The ride to the Northern Cheyenne Service Unit, the reservation's health-care facility, takes a little more than three minutes from Vanessa's house. Once admitted, she's placed in a hospital bed and given another bucket. Prince says Vanessa will stay here for observation while she sobers up before she is sent to jail for a night because of her illegal alcohol and pill intake.

Shortly after 9 p.m., the EMTs get another call, this time to an emergency involving a woman in Ashland, some 20 miles away. The steep and

LEFT: Odell Creek Road connects Ashland to Birney. Although it's just over 20 miles long, it takes more than an hour to travel. Such roads are common on the Northern Cheyenne

Reservation, which spans 693 square miles in southeast Montana.

RIGHT: Paramedics Charlee Prince, left, and Sandy Bruised Head, center, play a game of Yahtzee with dispatcher Karilyn Brady in the EMS building while waiting for an emergency call.



winding roads are treacherous this time of night, so they'll need to be as careful, and swift, as possible.

...

The Northern Cheyenne Reservation, located about 20 miles south of Colstrip, spans more than 440,000 acres in southeastern Montana. On a clear day, one can see jutting buttes of red shale and rolling hills of sage grass stretch toward the horizon. Lame Deer sits at the intersection of Highways 4, 39 and 212. Branching off these highways are numerous dirt roads, some of which lead to ranches, houses, or serve as roundabout routes to get from one end of the reservation to the other.

While the reservation's remote location gives it a certain Wild West allure, the distance to a major medical center can cause problems for those suffering from severe trauma or in dire need of emergency care. Though the hospital facilities are equipped with 24-hour urgent care, they lack the means and personnel to perform surgeries, do more than stabilize heart attack or stroke victims, or deal with other serious ailments. In the case of a life-threatening emergency, patients must be transferred to Billings. Sometimes, an ambulance carries patients 60 miles across Highway 212 to I-90 and then another 40 miles to Billings, which takes about an hour and a half. In particularly severe instances, some patients are transported via Life Flight helicopter into Billings, which takes

about 30 minutes.

It's more than just the reservation's distance to adequate facilities that makes it challenging to respond to emergencies—it's the reservation itself. Because of its vastness, it can take 30 minutes or more for crews to arrive at a scene, then an additional half hour or so to get back to Lame Deer to have the patient evaluated. Tack on the extra time for critically ill or injured patients to be transported to Billings and the remoteness can have life or death consequences.

Ken Sattler, a former EMT on the Northern Cheyenne Reservation, can attest to this harsh reality. One instance, he says, best illustrates the difficulties of responding to calls in such a remote location.

It was early in his career, so early that he hadn't even administered CPR on a patient yet. He remembers being dispatched to Birney, 21 miles southwest of Lame Deer, where a man had been kicked and beaten with baseball bats. The drive took more than 20 minutes through inclement weather on winding roads. Sattler and the other EMTs couldn't tell how long the man had been unconscious. The patient bled profusely and paramedics lost vital signs on the way back to Lame Deer. But there was no way for them to get blood because their facilities didn't have the means to store any, and because of the stormy weather, Life Flight wasn't an option. Sattler performed CPR on the man in the ambulance and ER for more than an hour before they lost him. Both men were

covered in blood at the end.

In 12 years as an EMT, this race against the clock was something Sattler faced too often.

"It's just the remoteness we deal with," Sattler says. "A lot of times, as a medic, it was quite frustrating."

Compounding the problem is the fact cell phone reception—with the exception of a few sporadic patches—is virtually non-existent on the reservation. If an emergency arises, Sattler says, the only way to notify the EMTs is by calling on a land line, and with miles separating neighbors and houses, merely finding a phone can be a major obstacle. Although many road accidents are called in by patrolling officers, incidents occurring on ranches or residences outside of the communities may take much longer to report.

"There's just no (cell phone) service," Sattler says. "There isn't immediate response."

Debby Bends, CEO of the Northern Cheyenne Service Unit, acknowledges the difficulties brought

on by the reservation's rural nature, but thinks a better understanding by tribal council members of the reservation's medical needs could improve emergency response. Bends, who was born and raised on the reservation, says she'd like to install satellite phones, which would require close cooperation with tribal government. But it doesn't appear that will happen soon. "We have a long ways to go in that area," Bends says.

One obstacle is funding, which is appropriated yearly by Congress to the Bureau of Indian Affairs, which divides it between 564 federally recognized tribes nationwide, and there is never enough funding to meet all the needs. The Northern Cheyenne Service Unit had a total budget last year of \$23.2 million to serve approximately 9,800 enrolled tribal members. For treatment the reservation health clinic can't provide, Bends says, the contract health care budget is about \$3.5 million.

Medical transfers to Billings, whether by ambulance or Life Flight, are covered by IHS funds, though sometimes reimbursement is secured if the patient has private insurance or is covered by Medicare or Medicaid. One helicopter trip to Billings costs nearly \$11,000 and last year Life Flight was used for transporting tribal members from the reservation 19 times. In five cases, the IHS was reimbursed. Though funds for these off-reservation services may be tight at times, Bends says, she insists the well-being of the patients outweighs the need to keep costs down.

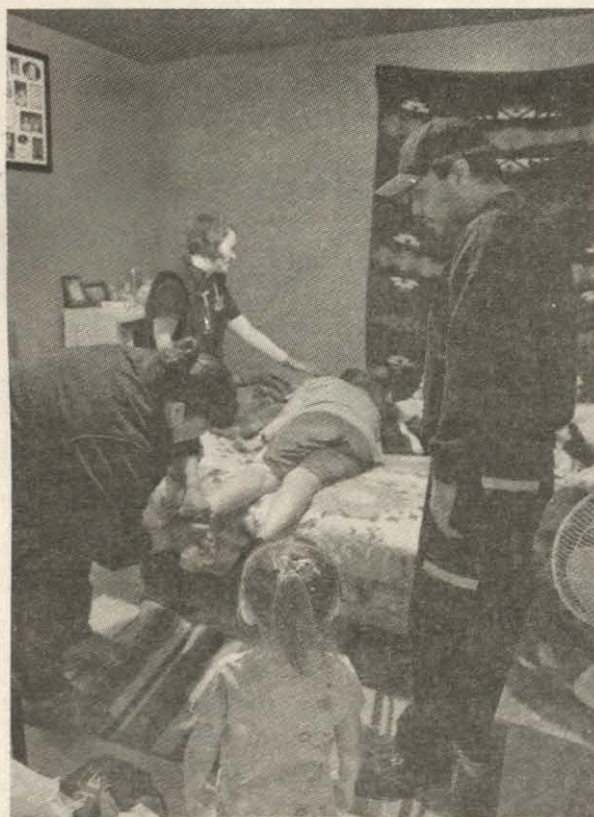
"If it's needed, if it's a life-saving measure, finances don't come into consideration," Bends says.

But that's not how Sattler remembers it.

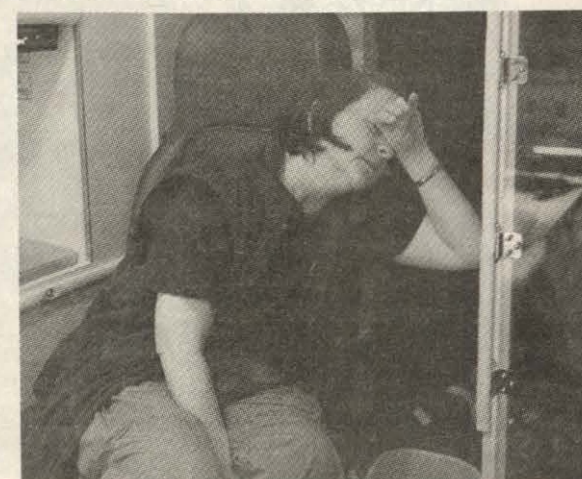
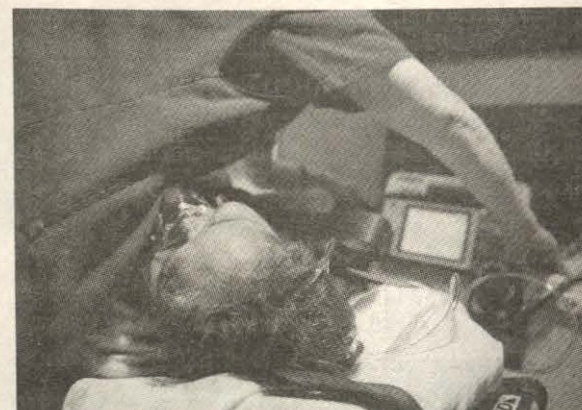
During his time as an EMT, he recalls how budgets dictated the quality of care patients would receive. At times, he says, administrators discouraged the Life Flight and ambulance transfers to Billings in order to save money, and, on several occasions, they talked of discontinuing Life Flight trips.

"The budget is kind of the driving force," Sattler says. Now a teacher at Lame Deer High School, Sattler describes himself as critical of the health-care system on the reservation, but only because he wants to see improvements.

"This community deserves better," says Sattler, who was made an honorary member of the tribe in 1993.



Northern Cheyenne EMTs attend to Vanessa, a 40-year-old Lame Deer woman, as her granddaughter looks on. According to family members, Vanessa had been drinking heavily and had snorted a crushed hydrocodone pill, which resulted in seizures.



TOP: Paramedic Charlee Prince checks the vital signs of a 60-year-old patient, who was unconscious when paramedics arrived. Family members say she failed to take medication for her liver cirrhosis, causing her ammonia levels to rise. BOTTOM: Prince takes a moment to rest after responding to a call in Ashland.

Among the services not provided at the Northern Cheyenne facilities is a dialysis center, but because 18 people on the reservation need dialysis, IHS provides a daily shuttle called Rez Run to take them and other patients to Billings. Charles Medicine Bull is one of them.

Medicine Bull suffers from hereditary kidney disease and takes Rez Run every other day. The shuttle leaves Lame Deer around 12:20 p.m., Medicine Bull says, and returns around 10 p.m. But Medicine Bull lives 25 miles from Lame Deer and has no car, so he must rely on friends to drive him to and from his house.

Medicine Bull's house lies off of a dusty tract of country road near Birney. His nearest neighbors, whom he doesn't know, are about a quarter-mile away. He lives by himself, with no cell phone and

only a Dell laptop to connect him to the outside world. Some windows on his house are boarded up, others shattered. A mangled barbed-wire fence surrounds his property and charred sections of earth are remnants of one-time fire pits. In his front yard is a dilapidated shed, its roof caved in with several wooden beams scattered about. An orange Toyota pickup sits on wheelless rims and a rusted mattress frame rests in its cab.

A cool breeze rustles the stray wisps of Medicine Bull's long, black hair. A plastic bag with Pepsi and Mountain Dew bottles flaps in the wind as he peels back the gold tin of a small Reese's peanut butter cup.

"I like my sweets," Medicine Bull says. "Even though I'm a diabetic."

There's a considerable amount of risk living so far out of town, he says, and, if something were to happen, he doesn't know how he would contact anyone.

"I'm scared out here," he says. "What if I have a heart attack?"

But as he sits in his fold-away chair Medicine Bull is reminded of why he remains here: It allows him to be free, on the land where his family has lived for generations.

"I live here on Mother Earth," Medicine Bull says, adding simply, "It's Cheyenne."

...

After a 20-minute drive down the tortuous path of eastbound Highway 212, the paramedics arrive in Ashland at a house draped in American and Marine Corps flags. A first responder crew is already on the scene and gives the EMTs the rundown: A 60-year-old woman named Henrietta is unconscious and unresponsive. Her family members told the first responders she suffers from a severe case of cirrhosis that renders her liver 10 percent functional, and she stopped taking her medication for a couple of days, causing her ammonia levels to skyrocket.

The paramedics find Henrietta sitting on the couch — eyes closed, head falling limply back.

"Henrietta! Henrietta!" Prince shouts

to try to rouse her. No response. Prince, Bruised Head and Little can't lift her large frame onto the gurney so they recruit family to help. Once in the ambulance, Bruised Head sticks an IV needle into Henrietta's arm and blood streams from the wound.

On the ride back to Lame Deer Prince keeps up her one-way conversation with the patient.

"Henrietta, open your eyes for me! You know where you are?"

She's stable now, here in the reservation ER, but because she needs to have the impurities in her blood flushed out, she must be transferred to Billings.

Little, who's been an EMT for almost 13 years, doesn't really mind the drive to Billings, but on especially busy nights, it can be draining. The dark expanse of Highway 212 stretches out in front of him; he's traveled this way so many times, he's memorized the treacherous curves and drastic elevation changes. Still, he keeps his speed around 75 miles per hour — the speed limit — and is alert for wandering deer.

At night, the countryside is reduced to a seemingly interminable abyss, occasionally

interrupted by a roadside light, or the sprinkled lights of small communities like Busby.

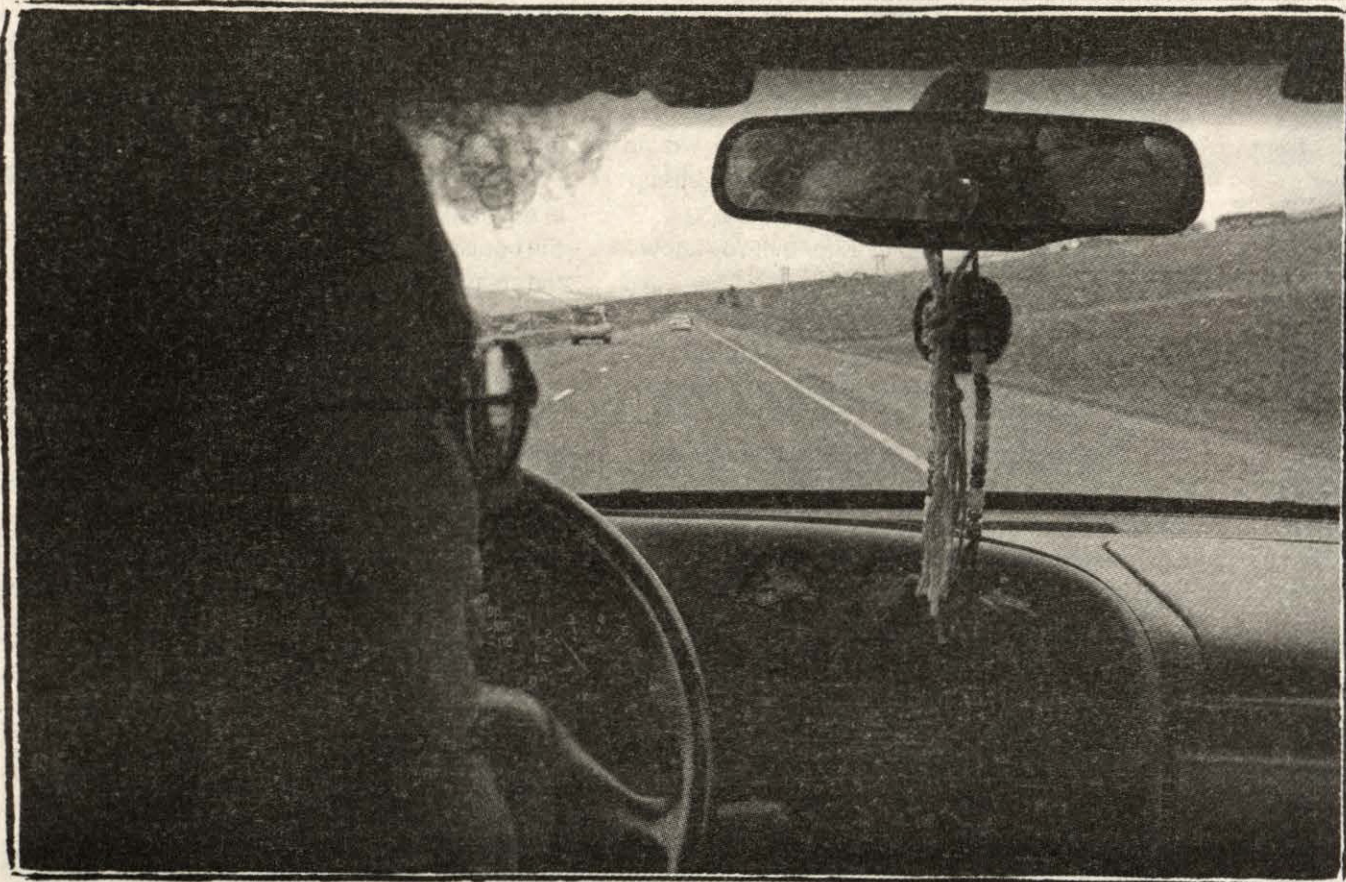
Prince furrows her brow as she checks Henrietta's vitals and movements, frequently jotting down her observations on a medical form. Even when the ambulance catches an asphalt ripple in the road, Henrietta shows no response, save for the occasional knee jerk and mouth quiver. Once they reach I-90, the road is bathed briefly in the lights from the Crow Reservation casino and gas station, but after they pass Hardin, it's back to the all-encompassing blackness.

Prince lifts Henrietta's eyelids to check if her pupils are responsive; instead, they are fixed, not seeming to detect the stale rays from the overhead fluorescent panels, and move back and forth only as Prince moves Henrietta's head from side to side. A layer of cotton-white saliva forms on her lips, and Prince dabs it with a cloth.

The ambulance passes mile marker 473 at 12:44 a.m. A faint glow from Billings looms in the northern sky — a sign that Henrietta's journey is almost over, at least for tonight. But Little and Prince still have miles to go.

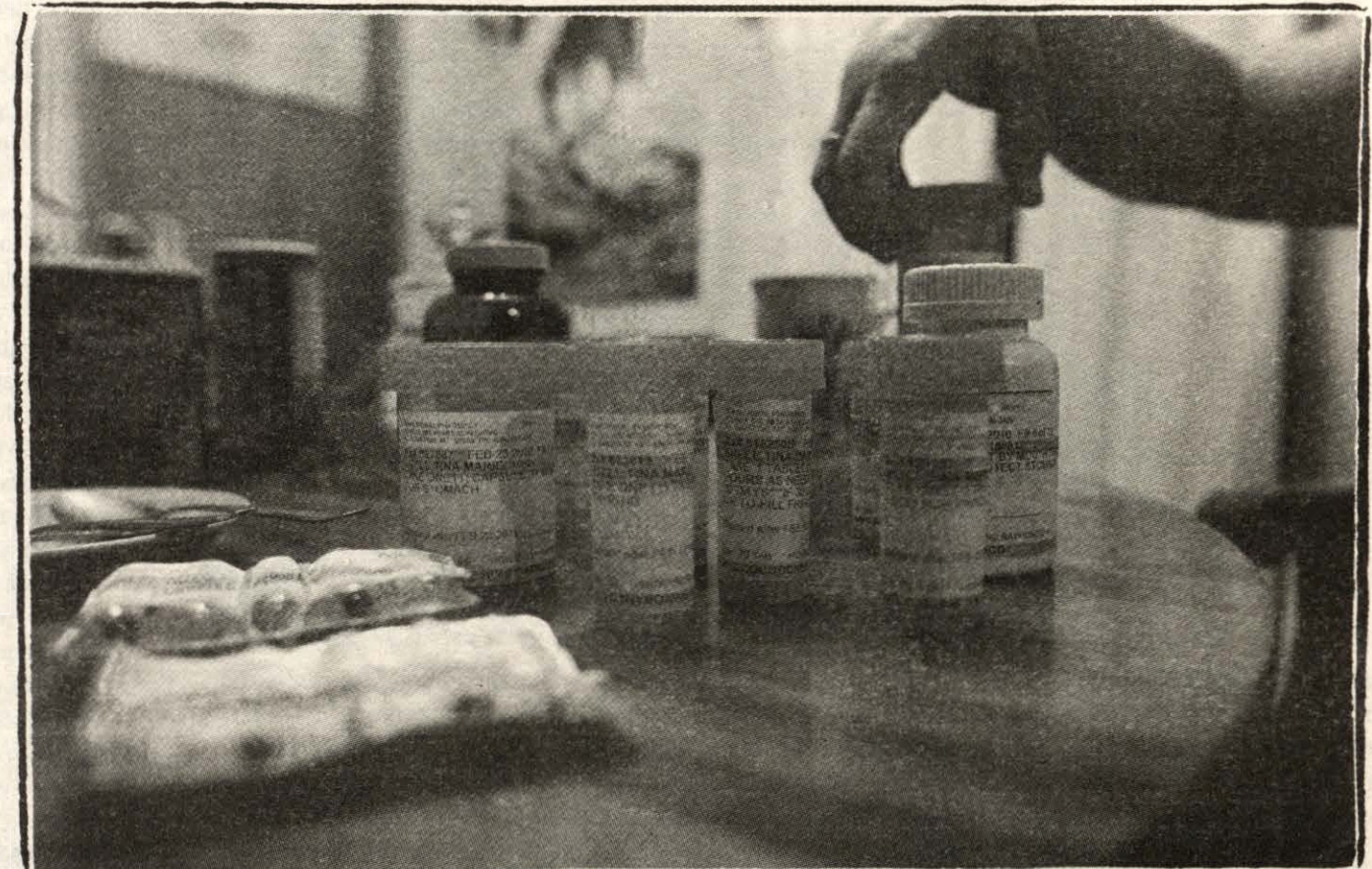


Charles Medicine Bull of Birney lives in a remote part of the reservation. His nearest neighbor is over a quarter of a mile away. Every other day, he travels in a van 125 miles to Billings for dialysis, leaving his house around noon and returning at 10 p.m.



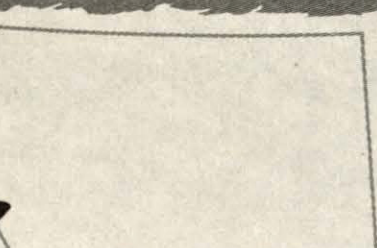

Tina Snell drives 27 miles from Missoula to pick up prescriptions from the Tribal Health pharmacy in Arlee. If her medications aren't available in Arlee, her next option is to go on to St. Ignatius, 42 miles farther.

Health away from Home



Snell takes as many as 26 pills a day just to feel "normal," she says. "I don't know what I'd do if they ever took the (Tribal Health) pharmacy away," Snell explains, "because there's no way I could ever pay for all my prescriptions."

URBAN

American Indian population
in Montana: 67,991
Percent of state
population: 6.2%
Percent of Indians
living off reservations: 40%

Written by
Karen Garcia

Photography by
Amanda Opitz

Lucille Tucker had
turned yellow, and her own
daughters didn't even realize
it.

Bilirubin from her faulty liver was slowly leaking
into her body, seeping into her bloodstream and
dyeing her skin a light shade of goldenrod. And still
no one noticed.

It seemed even the house she lived in in
Missoula was conspiring against her: muted yellow
walls and softening lampshades allied to swathe the
room's contents in a perpetual pale maize-colored
glow, concealing her body's eerie discoloration.
Lucille Tucker clearly looked yellow, but so did
everything else.

It was Lucille's youngest daughter, Tina, who,
after seeing her mother in the unaffected light
of the outdoors, called her older sister Karen in
February 2009 and observed that their mother
looked strange. Karen Neumiller, a registered nurse,
immediately drove to her mother's house and
marched 72-year-old Lucille into her comparatively
less yellow kitchen only to realize the whites of her
mother's eyes shone the color of sunflowers.

The jaundice prompted an immediate CT
scan and an array of blood tests. It was cancer,
the Missoula-based doctor told the family, and it
hadn't started in her liver. It had spread there from
Lucille's gallbladder, which was diagnosed as having
harmless gallstones almost 30 years earlier at an

Indian Health Service facility on Montana's Fort
Belknap Reservation.

All those years ago, IHS doctors told Lucille
gallstones were causing the
excruciating pain in her abdomen
and ordered her gallbladder be
removed via a surgery called a
cholecystectomy. At the time the
operation was invasive, requiring
a large incision, and recovery time
was extensive, unlike today when
it can be done with tiny incisions
through which surgical cameras
and instruments are inserted.
But doctors said it would relieve
her pain and prevent any serious
gallstone-related complications
from manifesting themselves in the
future.

If Lucille wanted to take the doctor's advice
and pursue the surgery, however, she would
have to pay for it herself: IHS refused to cover

the thousands of dollars it would cost for the
procedure, since she had been living off tribal lands
for more than 180 days.

*"I shouldn't lose services for
living off the reservation.*

*I just don't think it is fair that
we are penalized for that."*

- Karen Neumiller

Lucille, an enrolled member of the Ho-Chunk
tribe of Wisconsin, had lived on the Fort Belknap
Reservation with her Fort Belknap-enrolled

Assiniboine husband Bill Tucker for more than two
decades. After bearing six children and realizing
the economic limitations of reservation life, Bill
and Lucille packed up and moved to
Missoula in 1975. In doing so, they
effectively relinquished their access to
most IHS-provided health care.

They were urban Indians now,
violators of the 180-day rule, with few
options. Lucille and Bill did not have
private health insurance. They didn't
have thousands of dollars to pay for
the expensive procedure on their
own. Urban Indian health clinics did
not and still do not have the funds
or resources to provide much more
than a routine dental visit or a generic
asthma prescription.

So the gallstones stayed, and so
did the gallbladder.

Thirty years later, Lucille Tucker turned yellow.
She lost weight, her hair thinned, she stopped ▶

Karen Neumiller passes a bottle of diabetes medication to her sister Tina Snell. Their sister, Kim, left the medicine during a recent stay at Neumiller's home. Neumiller says it is not uncommon for Indian people to share prescriptions when they can't get to the pharmacy to get their own drugs.



eating. And on June 24, 2009, at 10:22 in the morning, four months after her diagnosis, she died in the home that had so cruelly concealed her plight in the first place, surrounded by family that knew it wasn't the walls that were to blame.

...

Back in 1975, when Lucille and Bill's family had just moved from the reservation to the urban center of Missoula, Karen Neumiller was still named Karen Tucker. And 14-year-old Karen Tucker, the students of Hellgate High School soon learned, did not take crap from anyone.

While Karen was busy fighting almost daily with peers she says were racist and mean-spirited, her younger sister Tina silently bore the harassment until she got home, when she would cry to herself and attempt to fend off the rapidly encroaching sentiment of unfounded self-loathing.

As the two daughters of Lucille grew older, their disparities in personality became more apparent. Tina moved back to Fort Belknap almost half a dozen times, citing cutting loneliness and an intense need for security as her reasons. Karen never went back—ever—and she doesn't intend to. Tina chose enrollment in the Ho-Chunk tribe (from their mother's side), while Karen is enrolled in the merged Assiniboine-Sioux tribe (from their father's), which shares the reservation with Gros Ventre Indians. The tribes signed the Fort Laramie treaties in 1851 and 1855, which, in exchange for

land concessions that ultimately set the reservation borders in 1888, guaranteed them certain rights, among them health care from the government.

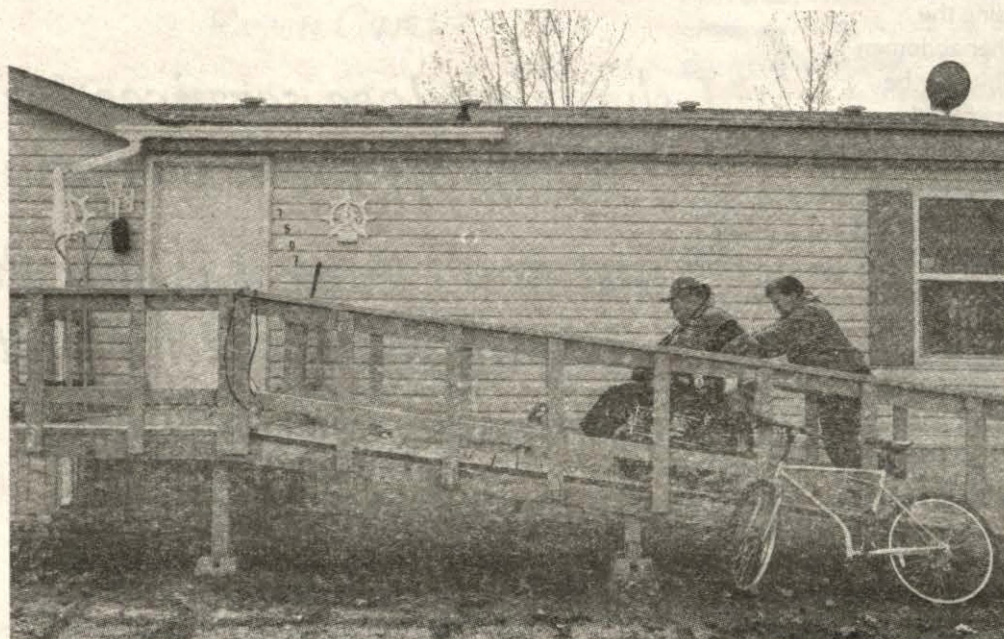
These two women, now 49 and 47 and different in so many regards, are at present very much alike in one seriously significant respect: both are currently unemployed, and with no private health insurance to cover their medical expenses, must rely on scant IHS services to obtain their prescriptions and any basic care they need. Meanwhile, bills for CT scans, ultrasounds, and specialty care providers continue to pile up and dig

the sisters deeper into debt — services IHS will not cover, simply because Karen and Tina no longer live on the reservation.

According to the 2000 U.S. Census, 66 percent of American Indians and Alaska Natives live in urban areas while 1 percent of the Indian Health Service budget is devoted to urban Indian health centers and clinics, such as the Missoula Indian Center. It has no budget for medical treatments, so the center can provide only outreach, prevention and referral programs for the urban Indians residing in the second-largest city in Montana.

As enrolled members of federally recognized tribes, Karen and Tina can still get direct care services from any IHS facility. These benefits include access to pharmacy supplies such as prescriptions, limited dental, and minor medical care. Anything more complex, like specialist care, X-rays, or lab work, is classified as contract care, and rigorous eligibility requirements (including residence on reservation or trust land) make it nearly impossible for the majority of Montana's Indians — 40 percent of whom live off the reservations — to obtain these specialized services.

Missoula's closest IHS facility is located on the Flathead Reservation, in St. Ignatius, about 45 minutes north. Since gas is expensive and time precious, Karen, Tina, and their older sister Sandy take turns embarking on the journey to get the group's prescriptions. Sometimes, the women can have their prescriptions transferred to the tribal health clinic in Arlee, cutting their commute nearly



Tina Snell pushes her brother-in-law, Lee Snell, up a ramp to their family home. For health reasons, Snell is not supposed to lift heavy objects or exert herself. Yet, caring for her family sometimes makes this impossible.

in half. But this convenience is not without its shortcomings.

In mid-March, Karen drove up the meandering U.S. Highway 93 to the St. Ignatius pharmacy to fill her prescriptions for anti-depressant and anti-inflammatory medications. The pharmacist politely informed her the wait would be at least two hours. Because Karen's newborn grandniece was with her and was fussy from vaccinations, she was reluctant to wait so asked them to transfer the prescriptions to Arlee where she would be able to pick them up soon. A week later, she was still without her medication.

"So far they haven't sent it to Arlee," she says, exasperated. "So now I'm waiting and not taking the medication that my doctor wants me to take because I either have to go all the way back up to Mission (St. Ignatius) to get it, or wait for them to send it down to Arlee."

But she is reluctant to sound critical. "I think that they are doing the best that they can," she adds quickly. "I'm very grateful for their programs, but as a community member who uses these services, it's a real problem."

To obtain even basic care at St. Ignatius, barriers must be navigated and hoops must be jumped through. Potential clients must provide proof of enrollment or descendency from an enrolled member, a copy of their birth certificate and Social Security card, and two proofs of residency (pieces of mail with name and current address). Then, if all the parts of this puzzle can be gathered, it is on to a hefty stack of paperwork.

"There's so many stumbling blocks and there's so much red tape and you just want to scream," Karen says, imparting a sentiment common among urban Indians who say they are being penalized for pursuing opportunities off the reservations.

Because Fort Belknap, like most Montana reservations, has an unemployment rate that hovers around 70 percent and poverty so pervasive that Karen compares it to a Third World country, it isn't difficult to understand why someone would choose to leave the reservation in search of better prospects, even at the expense of necessary social services.

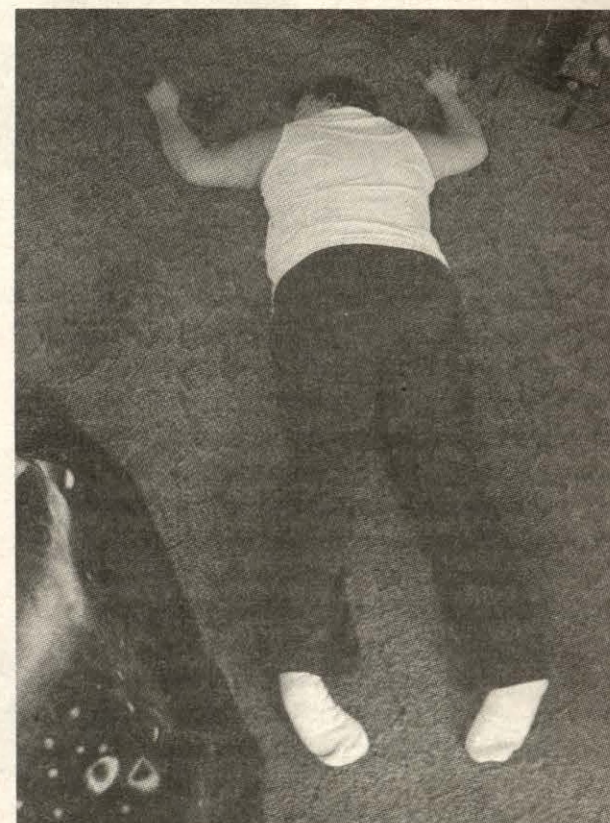
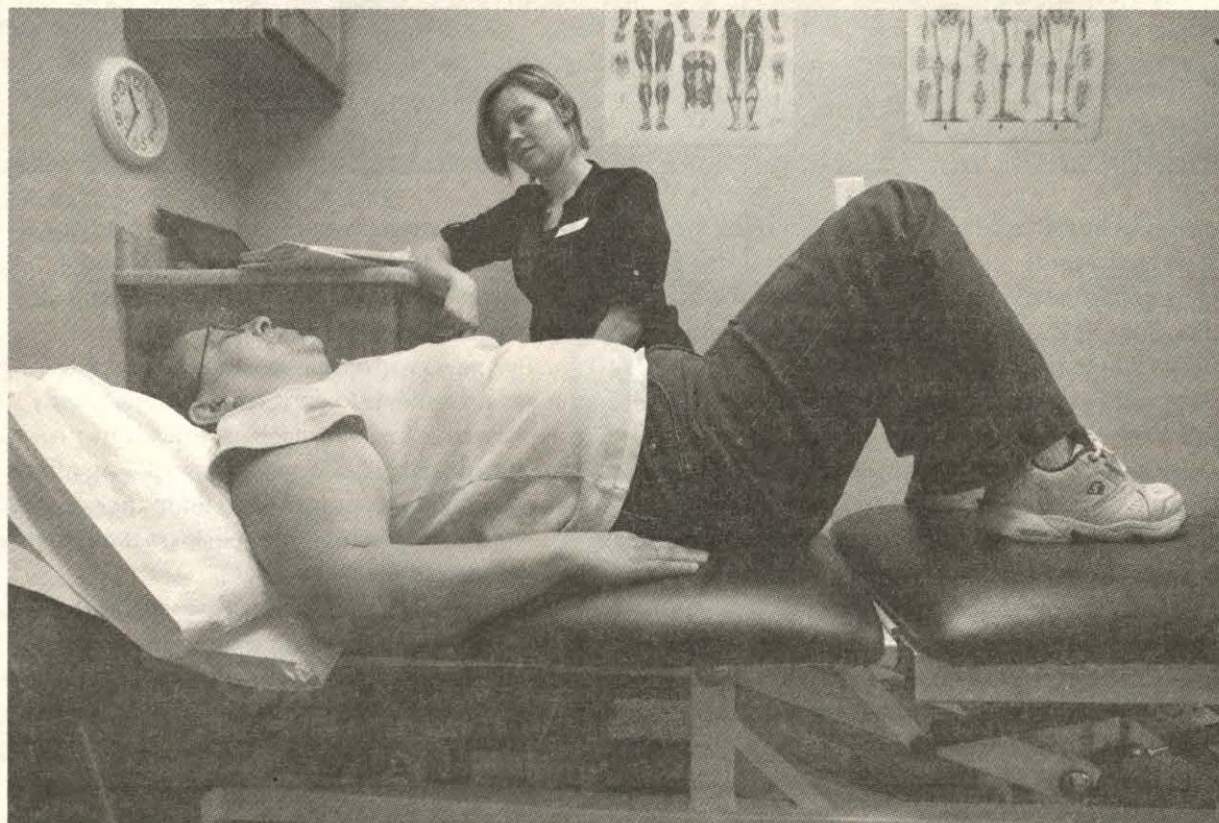
But Karen believes where an American Indian lives shouldn't affect access to health care.

"Just because I'm not living there and I choose not to live there doesn't make me any less Native," Karen says, frustration and anger tinting her tone. "And I shouldn't lose services for living off the reservation. I just don't think it is fair that we are penalized for that."

...

Tina Snell, Lucille's youngest daughter and Karen's younger sister, sighs heavily as she takes a seat and rests a black zippered bag slightly larger than a fanny pack on her lap. The table where she sits, based on its location, probably triples as the kitchen/living room/dining room table in her Missoula modular home. She sighs again, and one by one, slowly and resignedly unloads the contents of her portable medicine cabinet.

Fish oil for her high triglycerides. Metformin for diabetes. Cymbalta for depression. Amitriptyline for insomnia. Skelaxin for muscle spasms. Belladonna for irritable bowel syndrome. Mirapex for muscle spasms and restless leg syndrome. Cetirizine for allergies. Omeprazole and misoprostol for



Tina Snell receives treatment for a pulled groin muscle at Frenchtown Physical Therapy. Because she was injured while working at the Missoula Indian Center, Worker's Compensation covers the bills for her off-reservation treatment. Otherwise, Snell says, she wouldn't be able to afford it.

ABOVE RIGHT: Snell lies on the floor to alleviate the pain in her back. She frequently has to find a "place of rest" to combat her chronic pain.



Karen Neumiller holds a photograph of her and her siblings at her son Anthony's funeral. "He was so strong and independent," Neumiller says. "That's the way I like to remember him."

stomach ulcers. Hydrocodone and meloxicam for fibromyalgia. Levothyroxine for hypothyroidism.

"It's sick. It's just sick," she says as she exhales and shakes her head sullenly, staring helplessly at the assemblage of bottles now littering the table. Tall, short, fat, and skinny translucent orange containers, with the occasional solid white or clear green sticking out like sore thumbs.

Mercifully, direct care services cover the cost of Tina's multitude of medications.

"If they cut us off, I don't know..." her voice fades away, contemplating. "I'd probably have to move back because of this."

Tina began working an administrative job at the Missoula Indian Center in 1997, which provided her with health coverage, but she was forced to quit in 2002 at the urging of her doctor after stress-induced costochondritis, a chest wall inflammation, landed her in the ER several times.

During this bout of unemployment, bills not covered by IHS for treatment of her chronic medical

disorders began to pile up. When she returned to work at the center in 2005, 25 percent of her wages were garnished to go toward outstanding medical bills, but four years later she was again forced to resign due to recurring chest pains.

Her five sons are grown and have moved out, but Tina now shares her home with and cares for two disabled brothers-in-law, Floyd and Lee. Their monthly Social Security checks, along with the quarterly \$2,900 that Tina receives from the money brought in from Ho-Chunk casinos, help pay for groceries and rent. Medical bills are cast to the wayside in lieu of food and shelter.

Bill collectors harass her, doctors threaten to cease care if they don't see some money. One of her favorite providers, Dr. Raymond Howard, will be forced to discontinue Tina's services if her bill is turned over to a collection agency for defaulting on the payment from her last visit.

"I don't want to lose him because he's been my doctor for years and he knows all about me,"

she laments, carefully averting her eyes from the pill bottles still strewn across the surface of the kitchen/dining room/living room table. "I don't want to go to a new doctor."

Tina never expected she would be this sick, this early. She never knew it would be this bitterly complicated to find affordable, accessible health care. But most of all, she never knew moving off the reservation virtually erased her right to the services that were promised to her people in treaties signed so many years ago.

"It's just a slap in the face," she says, as the disappointment proceeds to cloud and manipulate her features.

...

It isn't surprising that after almost a year, Lucille's death still plagues the thoughts of her daughter Karen.

"I don't think she would be gone today if she would have gotten the medical attention that she

needed at the time," she says evenly, referring to the gallbladder disease that, if left untreated, can lead to cancer. "I don't think she would be dead today. And that is my honest opinion."

But Karen's musings, deliberations and judgments concerning her mother's death are forced to share mental space with another person, a person whose ashes are buried alongside Lucille's at the Missoula City Cemetery.

Anthony Neumiller, who would be Karen's oldest son, died at the age of 25 in January 2004 from an accidental overdose of fentanyl, a painkiller 100 times stronger than morphine. Suffering from anxiety, obsessive-compulsive, bipolar, and schizoaffective disorders while he was alive, Anthony would hallucinate, talk to himself, and invent imaginary friends. Since Anthony's blood quantum did not qualify him for enrollment in any Native American tribe, he was labeled a first-generation descendent, disallowing him from IHS contract care services. Twenty-two when his symptoms began to manifest, Anthony was too old to fall under the umbrella of his mother's health policy.

Karen and her husband Ed went bankrupt and lost their house trying to pay for Anthony's psychiatric appointments and frequent, overdose-provoked emergency room visits. Karen still carries her deceased son's International Student Identity card in her wallet, a reminder of the self-sufficiency, independence, and promise her son demonstrated when he went to study abroad at a university in Morocco from 1999 to 2000, before he was forced to drop out of school as he spiraled into the abyss of his mental illness.

Six years after her son's overdose — which left behind \$75,000 in unpaid medical bills accumulated over the three years preceding his death — she's faced with a fresh deluge of payment demands for her own bills and a disquieting sense of déjà vu.

Three weeks after quitting her three-year-long RN position at the Missoula Indian Center in November 2009, Karen started to experience sharp pains in the side of her stomach.

A series of out-of-pocket doctor and specialist visits, complete with a \$1,000 CT scan and several follow-up ultrasounds totaling a little under \$500, confirmed the existence of a mass. A mass, accompanied by its inextricable association with ambiguity and dread. Doctors urged Karen to have the tumor removed and biopsied.

Struck by a pang of sick familiarity, Karen realizes there is no chance of getting the mass removed. With no private health insurance and no help from her tribe due to her status as an urban Indian, Karen lacks the

financial flexibility to put thousands of dollars down just to schedule the surgery.

So, the mass, along with its ambiguity and dread, remains.

"I'm just keeping my fingers crossed that it's not cancerous," she jokes wryly as she glances almost imperceptibly down at her abdomen.

Karen is sitting in her mother's living room, which has now become her living room, nestled in the corner of a patterned sofa backed against the house's west wall. She and her husband moved into her mother's small home on the south side of Missoula after Lucille passed away. Karen is silent for a moment, considering her current situation and that of her dead mother's.

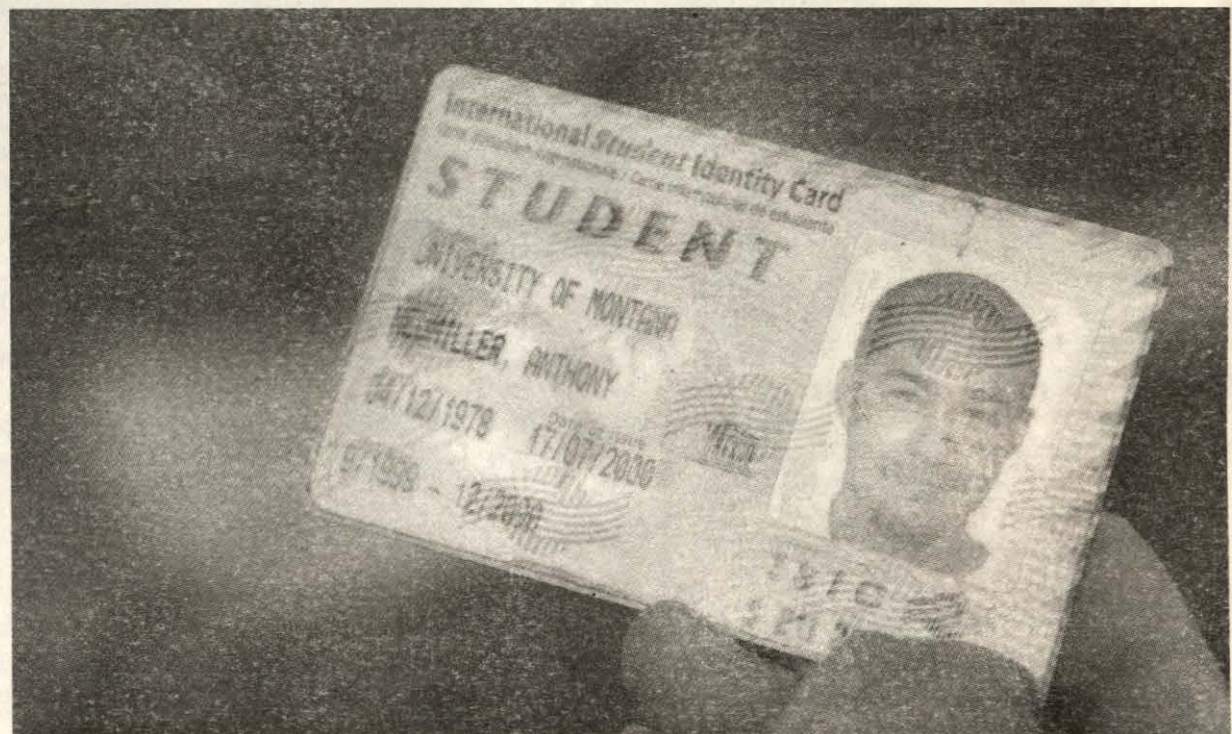
"I'm really angry about my mom," she finally says. "I'm angry that she's gone. I'm very angry at IHS because they wouldn't pay for her gallbladder surgery when she needed it."

She shifts her weight on the sofa.

"It does make me worried that history is going to repeat itself," she adds thoughtfully, and her voice is steady as she stares off into the room — her room now — that is still suffused with such unrelenting shades of yellow.

"I don't think she would be gone today if she would have gotten the medical attention that she needed at the time. I don't think she would be dead today. And that is my honest opinion."

- Karen Neumiller



Karen Neumiller holds her son Anthony's International Student Identity card. Anthony died in 2004 from an accidental prescription drug overdose. He was 25, and suffered from a series of mental disorders, which left the Neumillers with more than \$75,000 in unpaid medical bills after his death.

Young Lives Lost



FORT PECK



Population: 10,321

Native: 60%

Counties:

Daniels, Roosevelt

Sheridan, Valley

Reservation center: Poplar

Written by

Tetona Dunlap

Photography by

Carmen Irish

All day Roxann Bighorn sensed something was wrong. Her son Quinn had not returned her or her husband Spike's phone calls.

Even as Roxann, an adviser at Fort Peck Community College, pre-registered students for the next semester, her mind was on Quinn. As she made the five-hour drive to Billings to catch a flight the next morning, the feeling would not fade. Somewhere along the 330 miles of asphalt

that spans wide open fields, she had a premonition.

"There was this brightness over in the other lane and I saw this dog. It was a red dog. It was the same red golden retriever Quinn had as a little boy," Roxann recalls, her brown eyes brimming with tears, as a rueful smile begins to form. "I just knew in my heart of hearts that Quinn was gone."

When she was able to get cell service and Spike answered his phone, he said the words that tormented her the rest of the drive home: "Roxy, I found Quinn. He hung himself."

Quinn Bighorn, who died in 2005, is one among a growing number of young people to die from suicide in recent years on the sprawling Fort Peck Reservation in northeast Montana.

In a state that has the highest suicide rate of any in the nation—and twice the national rate—the toll of Native Americans stands out. Between 2003 and mid-May of this year, 23 Native Americans on the Fort Peck Reservation died by suicide, according to statistics from the Fort Peck suicide prevention coordinator.

Youth aged 10 to 24 are most at risk. Fourteen of the 23 from Fort Peck were in that age group. Perhaps even more remarkable is that nationally males kill themselves at rates three times that of females. Yet at Fort Peck, eight of the 14 young people who died were girls.

In the first four and a half months of this year, four

At Fort Peck, in the last seven years 14 young people have died from suicide. In 2010, by mid-May four youths had taken their own lives.

- Fort Peck Suicide Prevention

young people on the reservation have died by their own hand.

...

Out of the darkened gymnasium of Poplar High School emerge girls dressed in teal, fuchsia, hot pink and silver. They gather in the lobby to take a break

from dancing as they adjust their hair, take off their shoes and talk on cell phones. This year's prom theme is "Dance the Night Away". The basketball floor has been transformed into a techno club complete with black lights and glow-in-the-dark necklaces. Tonight is an event that brings students together to interact and be entertained. Many teenagers say safe and fun events are lacking in their community.

"Growing up in Poplar is kind of boring," Kacie Youngman, 16, a sophomore at Poplar High School, says the next day. Kacie did not formally attend prom this year, but she did go to see everyone in their dresses and tuxedos, including her older sister Lexi Longee, 18, who wore a turquoise dress, her favorite color. Kacie participates in cheerleading and cross-country, but mostly spends her time at home with family.

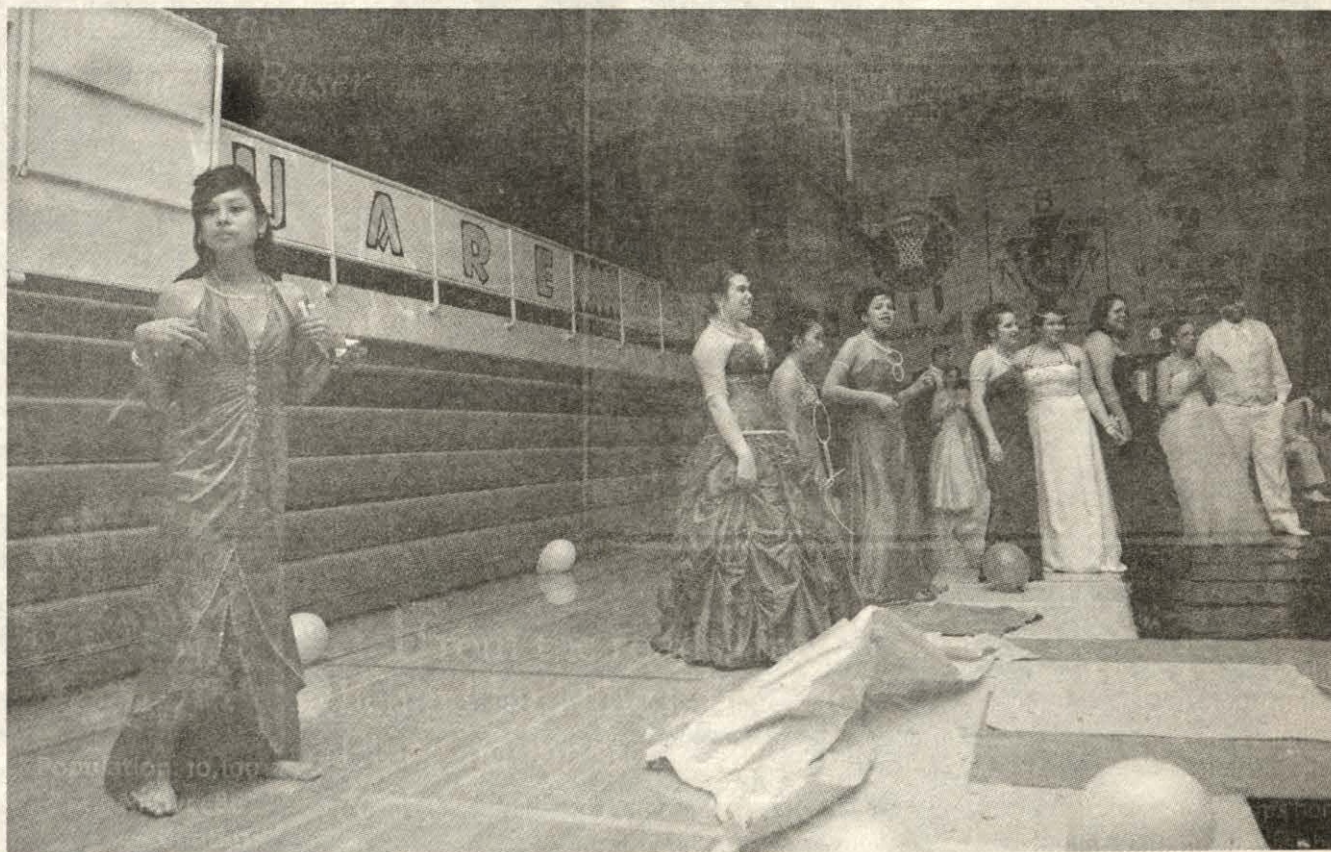
Kacie believes bullying and rumors sent through MySpace and text messages also make life here more difficult, especially for girls.

"There is a lot of drama at high school," she says. "If you barely bump into somebody or look at them they'll think that you don't like them. Boys get into fights and then they get over it. Girls hold grudges on each other."

Senior Evie Redboy also says that there's a lot of pressure on teenage girls.

"I think it's more harder on girls," she says. "It's always like, pressure to be drinking and doing drugs, and like, pressure into sex and what that's like and everything."

Evie lost



ABOVE: Girls at the Poplar High School prom gather to watch a group of boys dance to Michael Jackson's "Thriller". Young people say social events are scarce on the reservation. Since 1999, five girls from Fort Peck have committed suicide. LEFT: Roxann Bighorn and her younger son, Sean, stand outside their new home in Wolf Point. It was important to Bighorn to buy a house so that Sean would always have a place to call home.



"My favorite thing about her is that she sometimes sticks up for me," Kacie Youngman, 16, right, says of her sister, Lexi Longee, 18. Youngman says she also sticks up for her older sister.

a cousin to suicide after she endured bullying. Evie stayed out of school herself for two months because she was bullied and called a "slut" by other girls.

Shanni Moran, a 17-year-old junior, says young girls have nobody to talk to.

"A lot of times they maybe think about suicide because somebody else did it. They think, 'Oh, my life's hard, so maybe I should just do that too.'"

Lexi says she has attempted suicide three times. She appears soft-spoken, though her sister Kacie teases that Lexi, who is in choir, is prone to random singing outbursts. Lexi explains she overcame thoughts of suicide by talking to people. And in the end, she says, she always thought about her family and friends and how they would feel if she were gone.

Kacie, too, battled feelings of depression and thoughts of suicide.

Kacie says while at the prom she thought about the friends she had lost to suicide. "It's hard and sad and it hurts," she says. "You don't see them in school anymore, you can't talk to them. In this town there is a big problem with teenage suicide."

She lost two friends to suicide in the 8th grade, and most recently, and surprisingly, classmate Paulette Bemer. "She wasn't the type to do that," says Kacie. "She was really quiet and shy."

Pearl Hopkins, Paulette's grandmother, also remembers her granddaughter as a very quiet child. "That's just the way she was, that's how everyone knew her," she says.

Pearl sits outside her home in a folding chair as the wind blows across the field and into her front yard. The wind stirs leftover leaves from fall's early departure across brown blades of grass. Curled leaves and small branches lay sprinkled across a weathered trampoline in the yard.

"She would jump on the trampoline with the younger grandchildren and I could hear her talking and laughing then, but other than that she was a reserved person," she recalls.

Large tree trunk sections lay scattered in the front yard waiting for Pearl, 71, to split them. Pearl lives five miles from Poplar on a road that follows the train tracks west and falls south onto a gravel road. Her home is filled with Native American versions of Precious Moments

figurines, knickknacks and fabric hangings etched and stitched with sayings like "The Road to Grandmother's House is Never Long." Above her sink hangs a sign that states, "Home is where your story begins."

Less than 50 yards from her home is Paulette's grave. She was just 15.

Pearl says the family may never fully understand why Paulette took her life. But she does believe that more open communication might help prevent others from suffering the way her family has.

"A lot of times our Indian people are hard to talk to sometimes, they got their own ways, and they won't change," she says. "They don't tell and they keep things in, so they need to talk things out more with their families."

A month after Paulette was buried a ceramic angel stands in for a headstone that has not yet arrived. Her grave is covered in flowers. A Rockstar energy can sprouts from the soft dirt, probably left there by Paulette's sister, Pearl guesses. Next to the can is a poem that says, "May the Great Spirit watch over you, for he knows the path you walk and he will guide your footsteps gently."

Pearl circles her granddaughter's grave as she recalls how many people turned out for Paulette's funeral.

"Sometimes it takes tragic things to bring good," she says. "Sometimes God works in mysterious ways. We don't always understand. She brought all our families close together and now we are all getting along and are close to each other. That is the way it should be."

Pearl is sure it is the way Paulette would have wanted things. In a letter she left for her family, she wrote, "Take care of all my relatives."

Pearl points to the sky and moves her finger in a circular motion. After Paulette was buried mourners released black and red balloons. Pearl says that as the balloons rose skyward they appeared to form a "P." Then an eagle circled and flew away as the balloons dissipated.

"He took her home," Pearl says of the eagle. "It was protection; it was a good sign."

...

Quinn's death devastated the Bighorn family and that void now spans thousands of miles. Roxann and Spike divorced in 2007 and

Spike moved to Washington, D.C. He is the chief operating officer with New West Technologies, an engineering, technical services and management consulting business. He eventually remarried and his wife recently gave birth to twin girls.

"Statistics say your family either grows closer or breaks apart after a suicide. We were one of the statistics where the family broke up," Roxann says.

Roxann says she and Spike maintain a strong friendship, focused on their other son, Sean. Roxann worries about him, in part because he not only lost a brother, but also his family. The two are trying to make their new house in Wolf Point into a home.

The smell of white hyacinth wafts from a vase as Roxann and Sean sit in the living room. Their entertainment center is adorned with frames housing baby photos, school pictures and Quinn and Sean's senior portraits. On the floor sits a

drawing waiting to be hung on the wall. Behind the glass are the happy faces of Quinn, his girlfriend and their two sons, Jerron and Patton, now 6 and 5, who live in South Dakota with their mother.

Keeping with tradition, the Bighorn family burned most of Quinn's possessions. However, Roxann could not bring herself to burn everything. She keeps a plastic bag containing letterman jackets for Quinn's sons. On her right arm she bears the same green Brockton High School ghost warrior mascot that Quinn had tattooed on his arm.

"When you go through his stuff you can still smell him," Roxann says, holding the letterman jacket to her face. "He always wore that Michael Jordan cologne."

Quinn was everybody's star. He was handsome and athletic, with dark hair and eyes, accompanied by a playful smile. Quinn is in the Montana High School sports record book's top 10 for the most

points in a season with 748. He is also ranked 7th on all-season scoring with an average of 29.9 points per game.

Yet for Spike, the two had more than just a father-son relationship. Spike also watched his son from the sidelines as his basketball coach during his sophomore and junior years. Quinn's basketball jersey with the number 23 hangs retired inside the Brockton gymnasium. The football field bears his name. Spike says watching his son play basketball was one of the most fun and exciting times in their lives. He describes his son as dynamic and aggressive on the court, but off the court completely different.

"He was a very sensitive person," Spike says. "People thought he was introverted. On the court he was confident, but off the court he wasn't so much." His son liked to draw in his spare time and kept a journal, but sports was his outlet and

Pearl Hopkins stands beside her granddaughter Paulette's grave, a short distance from her home. Paulette is the second granddaughter Hopkins has lost to suicide in the past five years.



how he identified himself.

In his junior year, Quinn tore his ACL. His parents had insurance through their jobs, which paid 80 percent of the bill while the Indian Health Service paid 20 percent. However, when Quinn was an assistant coach for the Brockton football team, he tore his ACL again. As an adult at age 23, he no longer had insurance. Though he was eligible for IHS care, elective surgery for a life-threatening injury was not possible due to lack of funding for off-reservation medical services.

His family believes his injury played a role in the depression that was a contributing factor in his suicide.

Looking back, Spike can see that Quinn had signs of depression. He often wishes he would have gotten his son help or had gone to live with him. But Quinn always said he wanted to be left

alone and Spike respected his wishes. After his son's death, he received grief counseling for two years and traveled around the country speaking at workshops and conferences.

Spike remembers standing outside of Quinn's house waiting for the cops to arrive. He struggled to catch his breath, but the lump in his throat made it hard to breathe. It was a lump that stayed there for months. Spike says he never felt angry with Quinn, even as he held and talked to his body the night he found him.

"I did the best I could as a father, I did everything I could. You don't control their lives," says Spike. "I can't take that responsibility."

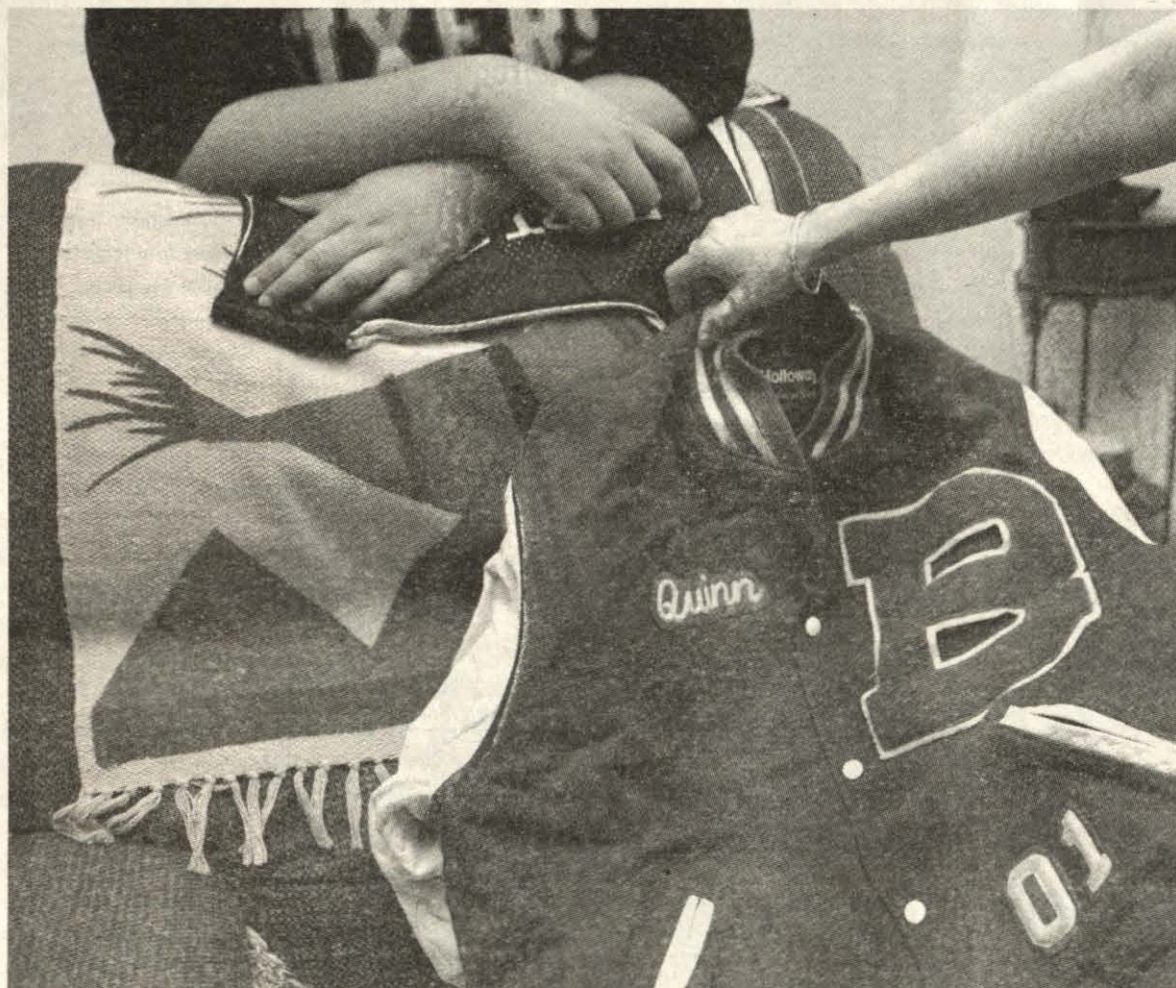
Roxann says Quinn was at "the mercy of IHS" and surgery was years away, if ever, because he wasn't at risk of losing his life or a limb. "I think that is what led up to his depression," she says. "He was

never able to recover from that injury.

"Basically you can walk around with cataracts or a torn rotator cuff for the rest of your life because it's not life or limb."

...

The American Foundation for Suicide Prevention states that even though most people who are depressed are not suicidal, most suicidal people are depressed. More than 60 percent of people who die by suicide suffer from major depression. Some common symptoms of depression are lack of interest in previously enjoyed activities, fatigue or loss of energy, insomnia, increased use of alcohol or drugs, feelings of worthlessness and significant weight loss or gain. The treatment of depression is effective 60 to 80



LEFT: Roxann and her younger son, Sean Bighorn, display the letterman jacket Quinn used to wear. It is one of the few items they kept after his death. One day, when Quinn's sons are old enough, they will have his old uniforms and letterman jackets to remember him by, she says.

RIGHT: Soon after her son's death, Roxann had the Brockton High School ghost warrior mascot tattooed on her right arm, the same tattoo her son Quinn had.

percent of the time, but according to the World Health Organization, fewer than 25 percent of individuals receive adequate treatment or are even diagnosed.

The Indian Health Service, the tribal government and the school district have rallied to address the crisis of youth suicide, but the issue hasn't always received the attention that it has recently.

IHS on the Fort Peck Reservation employs five Ph.D psychologists, in addition to suicide prevention coordinator Sherl Shanks, who works on behalf of the tribes to counter the issue of suicide in the community.

"There are so many crises that they are dealing with," Shanks says of the victims. She cites a "breakdown in families" and adds that "even good families" have suffered the loss of family members taking their own lives. But, she cautions that there is no single answer, or often even a reason anyone can pinpoint.

"I don't think they want to die," she says. "They just want to end the pain in their lives."

Counselor Charlie Whisenhunt agrees that family issues play a role in students' mental states.

"It's an issue of what happened last night," says Whisenhunt, referring to students who deal with drug, alcohol and sexual and domestic abuse in their homes.

Whisenhunt came to the Fort Peck Reservation in the early 1980s to research fetal alcohol syndrome for his Ph. D from Columbia Pacific University. Today he serves many roles: director of special education, school psychologist, and coordinator for mental health services in the Poplar school district.

For a time IHS had only one person in the school district who dealt with mental health issues, he says, but at present "it's really an embarrassment of riches" in terms of staffing.

In the Poplar school district, the largest on the reservation, six mental health counselors serve the students. Two more mental health counselors are employed by an outside agency.

"It's a big unit to have for a district this size,"

says Whisenhunt as the sound of girls laughing and lockers slamming reverberates into his office from the outside hallway, "but what we have found is because of the numbers, it's necessary."

However, he cautions that staffing alone is not the solution.

"Now they are all beefed up and that's great, but that doesn't last long usually," he says. "Money is not going to fix this problem; the community has to rise up."

"I don't think they want to die," she says. "They just want to end the pain in their lives."

*-Suicide Prevention Coordinator
Sherl Shanks*

Though boys commit suicide more frequently than girls, females have a more frequent attempt rate and Whisenhunt says the numbers of girls attempting suicide at Fort Peck coincides with national statistics. The difference is that at Fort Peck the rate of completion is higher because girls on the reservation choose more lethal means to end their lives.

"We need to teach coping skills and life skills. They need a repertoire of choices besides suicide (and) we need to lengthen that list (of choices)," says Whisenhunt.

Whisenhunt notes that all the psychologists in the school district are certified as both school counselors and licensed mental health practitioners. That's fortunate, he says, because the school district goes through "some pretty dry times as far as support is concerned."

Gloria Collins believes support and collaboration are keys to helping the community heal. Collins grew up on the Fort Peck Reservation, but lived in the Southwest until a few months ago. As a tribal member and a clinical psychologist, she has returned home to help.

"I know things can be good, there can be healthy families that are united," Collins remarks after a meeting in the tribal council chambers that involved all facets of mental health on the reservation. "If we all step up like we did today, that is the start," she adds. The room was filled with several members of the tribal council and community leaders. Shanks was there along with Doug Moore, acting chief medical officer at Fort Peck's IHS and head of behavioral health, and

Ken Smoker, director of the Tribal Wellness Program.

Collins called the gathering "a healing process" and an important acknowledgment of suicide as a pressing issue at Fort Peck.

She, too, says the responsibility must fall on the whole community, not just individuals. The group scheduled meetings every other Monday to discuss how to address suicide in the community.

Roxann Bighorn was at the gathering too, sitting at the head of the council table. She called the meeting historic in terms of the collaboration.

Her son's suicide remains the most difficult part of Roxann's life. But tribal customs have given her some solace.

On the night the family found Quinn, they held a pipe ceremony and sweat to guide his spirit to the other side.

Roxann recalls that night inside the sweat lodge, she could see Quinn standing directly in front of her when she closed her eyes. With each round of the sweat, when the flap covering the lodge was opened to let in the cool air, Roxann says her son's spirit traveled further to the spirit world. He always had his dog Reggie by his side, but he kept turning back like he didn't want to leave his family.

"It's all good Quinn, just keep going on," Roxann called to him, quoting her son's favorite phrase, "It's all good."

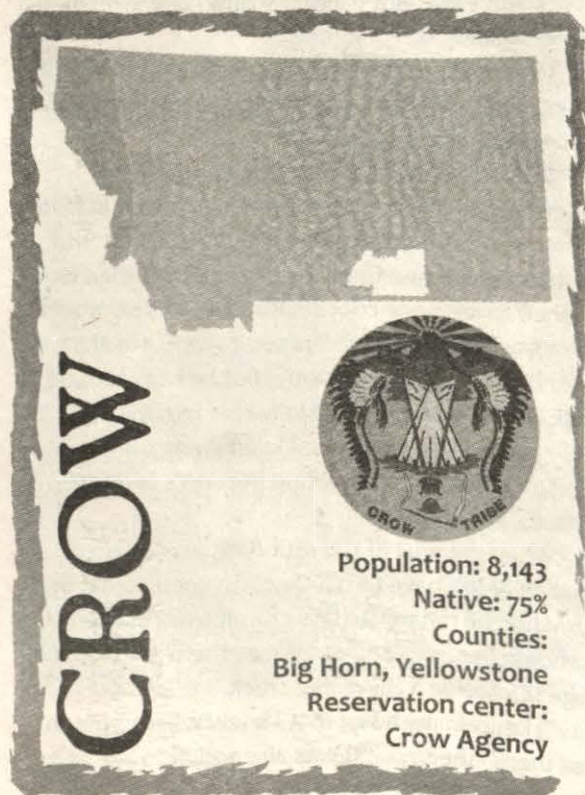
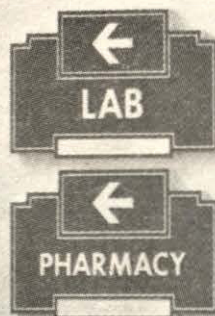
When the final of the four flaps was opened, Roxann didn't have to tell Quinn to keep going. In her vision he ran toward his grandpa Norman and grandma Deremus and embraced them in front of a huge tipi beside a glistening creek.

"I knew in my heart that I knew where my son was then," she says. "It was all good."



Treatment for Distrust

Written by
Cody Bloomsburg
Photography by
Eric Oravsky



Alice Mae LaForge is going to die when she is 89. She'll be 86 this September.

Her smile turns into a rolling, vivacious laugh as she sets her own expiration date from the comfort of the chair where she spends most of her time. She jokes about how she doesn't get around much anymore, and that sitting between the arms of the black, office-style chair near her kitchen table is what she does most often. But as she says it she starts to laugh again and the afternoon sunlight coming through the window turns her tan face golden, showing liveliness in her dark eyes more befitting a woman half her age.

Myra Lefthand sits next to LaForge at a small oak table in her home in Crow Agency. Both women are members of the Crow Tribe, also called the Apsáalooke Nation, and each finds levity in LaForge's mock self-prophecy. The basis for LaForge's prediction is that her mother and her sister (who was Lefthand's grandmother) both died at 89. There is nothing morbid or escapist in the jest; she just gets a kick out of telling it to her doctors, and sometimes, to her family. In truth and in tone, it is more of a promise to have at least three years left with them. But for an outsider, the tone could be overshadowed by the bluntness of the words if they don't understand that, in Crow culture, finding humor in all aspects of life is part of how they live it.

A lifetime of waggishness has manifested itself

in long laugh lines reaching from LaForge's eyes back to her shoulder-length hair, which still holds enough black to show it was once pure raven. "I don't know when I'm going to go; might go down like that," she says and makes a falling-tree motion with her hands, followed by more laughter.

Their sense of humor is just a small part of a unique and lasting culture of subtleties and quiet respect that can take non-Crows years of interaction and question-asking to understand. The fine-drawn mores are sometimes lost on non-Indian physicians and other medical professionals who provide care for the tribe through the government-run Indian Health Service facilities on the reservation. Stepping on these customs extends unintentional insults to tribal members and creates barriers of distrust and miscommunication between doctor and patient, adding an extra burden to a system that has historically been underfunded and understaffed.

Lefthand is the community health educator for the Crow/Northern Cheyenne Hospital (the only IHS hospital for the two abutting reservations) and has worked for IHS for 30 years. Sometimes when she's in her office one of LaForge's doctors will stop

by and ask Lefthand to go and talk to her because LaForge is talking about dying again. LaForge has high blood pressure and cholesterol problems, as well as diabetes and issues with her thyroid, so check ups are frequent. Of course Lefthand will go visit LaForge, but not so much out of concern as out of respect for an elder. But the failure of a non-Indian to tell when a Crow person is joking is a small symptom that leads to a more serious complication for those treating the Apsáalooke.

The tribe is a matrilineal society structured in a complex clan system that is still in use today. Modesty and humbleness are mainstays of the culture and the system has built-in societal safeguards to preserve those qualities in its members, such as the teasing clan.

Children are born into their mother's clan, but the members of their father's clan become the children's "teasing clan." The role of the teasing clan is, just as the name implies, to tease clan members about anything in their life to prevent them from taking themselves too seriously or becoming arrogant. At first blush, the teasing may seem ruthless; no problem or area of a person's life—no matter how personal—is safe from

sarcastic critique, even if the clan member didn't bring it on himself.

Recently, one of Lefthand's clan brothers was hospitalized for a gallbladder problem. She and other members of his teasing clan frequented his room to check up on him and spread the joke that he was in the throes of giving birth to twins, and he was dilated to 10 centimeters and the babies would be there any minute. Her clan brother yelled at his clan members to get out, Lefthand says, not because he was offended, but because it pained him too much to laugh.

Health care providers often mistake scenes like this for visitors seemingly torturing or ridiculing patients, Lefthand says. The doctors and nurses, thinking they are looking out for the patients' interests, get upset with the clan members, but in reality they are meddling with culture and customs. The patients, in turn, can get frustrated with the medical providers, and get upset with having to explain the situation. Communication suffers and the doctor-patient trust is compromised over a misunderstanding rooted in the best of intentions. Given the intricate and pervasive nature of the clan system, as well as the other aspects of culture that hold a great importance to Crow people—such as kinship ties, personal modesty, and placing the respect of others ahead of one's self—shadows can fall between the doctors and their patients.

This, tribal members say, has led to Crows feeling hesitant to question doctors for clarifications about their treatments and to sometimes ignore directions altogether because they don't understand their importance or don't trust the doctor's expertise. Many leave the exam room confused about what they actually need to do to get better, what pills to take, what to eat, let alone why they are sick or how sick they really are. In the worst cases, patients have had experiences that make them refuse to seek the health care they were promised by the U.S. government through treaties in the mid-1800s.

It was chest pains that made LaForge go to the emergency room at the Crow hospital the last time.

She was put in an exam room and monitored for a few hours by a doctor who, she says, gave her the impression he thought she was too old to be treated and there was nothing he could do for her. Once her blood pressure returned to normal and her heart rate stabilized, he prescribed painkillers and released her. Hurt by this experience, she ▶



OPPOSITE: A painting of Chief Plenty Coup adorns the waiting area of the Pryor Health Station. Pryor residents say they feel forgotten by the Indian Health Service because of a high turnover rate among providers at the clinic. BELOW: Myra Lefthand, whose Crow name means "One who helps people," has worked for IHS for 30 years. Now a community educator, her job is to teach health care providers about Crow culture.

will no longer go to the ER and instead waits for an appointment with a physician she knows and trusts. Now when she gets chest pains she places a nitroglycerin tablet under her tongue, waits for it to dissolve and hopes her prediction of 89 holds true.

In the IHS system, Crows don't get a primary physician. They simply make a medical appointment and are examined and treated by the IHS professional on duty that day. LaForge has been able to build relationships with a few of the doctors at the Crow hospital, but even though she says she trusts them, her actions show the disconnect between her and her providers.

Currently, she takes seven different medications each day, but it should be more. She almost never takes the prescribed painkillers, and has one prescription she has no clue as to why she was prescribed it, so she just doesn't take the drug. She feels OK, she says, so why take it? Likewise, she was diagnosed as a borderline diabetic 10 years ago. The doctor told her she could control the disease if she changed her diet and got more exercise, but she decided not to. The condition has worsened and now she controls the disease with twice-daily insulin injections, but she still eats how and when she wants. In her book, she's OK, so why change it?

The heart of this issue is not a perceived lack of respect for Apsáalooke beliefs and practices by IHS physicians, and nor are Crow patients placing the blame for the problems solely on the doctors' shoulders. The tribe and medical community are promoting programs to help physicians learn more about the customs and culture of their patients, and likewise, to educate patients so as to foster better understanding, communication and trust between the two groups.

In 2001, the Messengers for Health on the Apsáalooke Reservation was started, using grant money from the American Cancer Society. The messengers are respected women from the Crow

community, like Lefthand, who have been educated about cervical cancer to teach other Apsáalooke women about the disease and the necessity of

the messengers, is also working with Lefthand and other messengers on the burgeoning Apsáalooke Health Advocate Program, which is aimed at

directly addressing the different issues that cultural misunderstandings cause between the Crow people and their providers. The advocates act as a direct link between IHS professionals and the Crow community, answering questions the professionals may have about culture and also explaining the practices of IHS to the people it serves.

Dr. Tom White is one of two OB-GYNs at the Crow hospital. He lives in Hardin, just off the reservation, and in the three years he's served at the hospital has also involved himself in the messenger program. He spent the first 27 years of his post-residency career working in a private practice in his hometown of Kalamazoo, Mich., serving patients who were primarily white and upper-middle-class. The doctor he replaced at IHS had been working at the Crow hospital for 20 years and stayed on for White's first month. Even with the guided transition, White has still run up against cultural misunderstandings, which McCormick and the two programs have helped him to resolve.

The clan system establishes a broad network of relationships across families so that a teenage girl may have several women she calls mother. The strength of these relationships means the girl may want one or more of her non-biological mothers to be in the room during an exam, but intricate enough that she won't feel comfortable answering certain questions about her sex life, or her body in front of them, nor will she want certain information shared with them. Walking this line, White says, was hard to master, and he can see how running afoul of these

boundaries could mean damaged trust between patients and providers.

The Crow concept of modesty, White says, has also been an issue that took some getting used to. Women who have already given birth to two or



TOP: Alice Mae LaForge, like 85 percent of Crow people, speaks Crow as her first language. She always takes one of her daughters with her to medical appointments to avoid misunderstandings.

BOTTOM: Charlene Laverdure, 67, has her blood tested at the Pryor Health Station. She watches her diet, she says, but still has high blood sugar levels.

testing. Women have always held a respected place in Crow culture and the goal was to bridge the gap between the physician and the patient with an educated member of the patient's own community. Alma McCormick, the coordinator for

more children still feel the need to remain covered during an examination and are at sometimes hesitant to even be examined, he says.

For White though, the most important medical concern that the programs have helped with is a custom of pregnant women eating clay. White says clay consumption has been linked to anemia, and causes problems with bowel function. Whether the craving for the clay is caused by the anemia or the ingestion of the clay causes the anemia hasn't yet been determined, White says. Regardless, it still puts doctors in an untenable situation. On one hand, his patients and their unborn children would be better off medically without the clay, but on the other, "It's a tradition that has gone on for hundreds and hundreds of years and you can't just stomp all over that," White says.

Working with the messengers, White says, the medical staff has found a way to remain sensitive to Crow culture while helping patients understand the medical reasoning behind his request that women stop eating clay. And that, McCormick says, is the type of interaction it will take to bring the two groups to mutual understanding.

Closing the divide between the worlds of the providers and the Apsáalooke people they serve just takes time and sincerity.

For 10 years, Kristine Judd worked as a clinical laboratory scientist at the Pryor Health Station, the only other IHS facility on the Crow reservation. Located in the hamlet of Pryor, the small clinic is about an hour and half drive from the Crow hospital. It's open five days a week and physicians work there on a set rotation, so if the scheduled doctor is out sick, there will be no doctor in Pryor that day.

Judd had worked in a clinic in Billings for about 20 years before making the switch to IHS. In Billings she had done mostly lab work with little patient contact, but in Pryor she had to draw and test blood from people with conditions like diabetes or high cholesterol and monitor their treatment. It

meant almost constant contact with a people she knew nothing about.

"Thirty miles down the road it's a whole different culture," Judd says. "It's a whole different world."

Her patients were scheduled to come in from as often as twice a week to as infrequently as four times a year, but Judd saw them all almost every day just by living in the small town. Even though she became a regular sight in Pryor, Judd says it

services for her patients. Soon, she says, they became more than just patients. She was welcomed into their homes. She became godmother to a colleague's baby.

"I loved my people," Judd says. "I loved what I was doing."

In the decade in which she served at the Pryor clinic, she repeatedly told her IHS supervisors that consistency was what her patients needed most. Too often, she says, a crisis would occur at the

Crow hospital and staff and resources would be lost from the Pryor clinic to make up for shortages at Crow Agency. Then last July she got the orders that led to the end of her career on the reservation.

Report each morning to the Pryor clinic, she was told, but then get into a government car and drive 70 miles to Crow Agency and work a shift at the hospital.

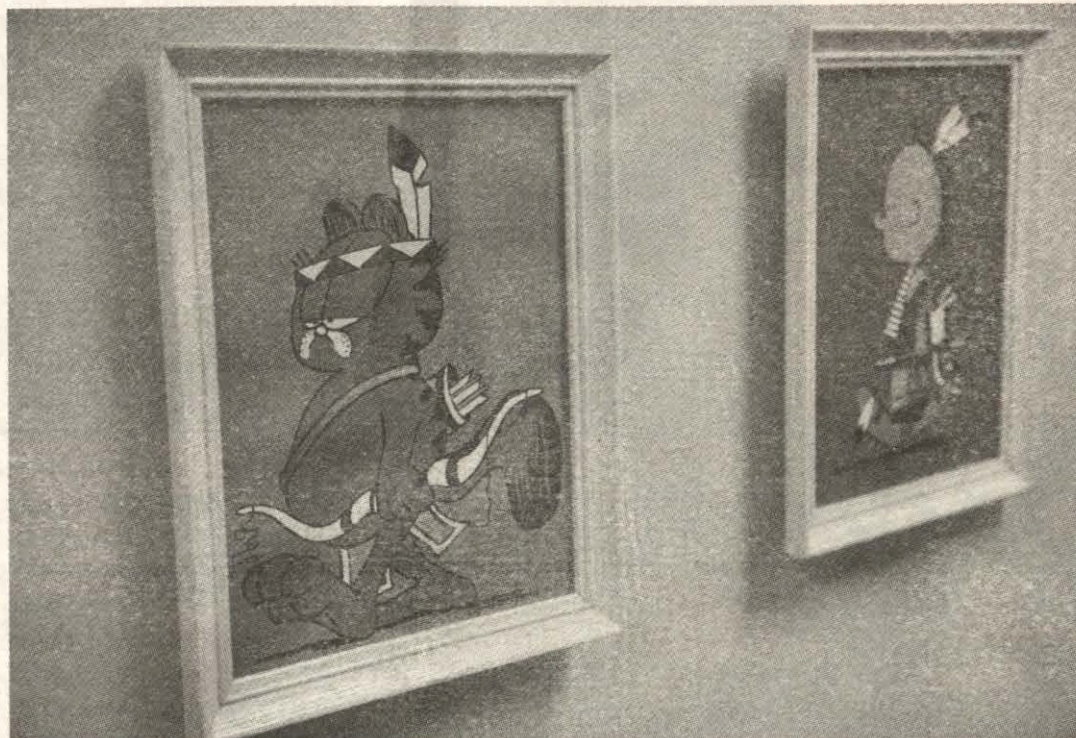
One way or another, she would be forced to leave her patients behind. With a heavy heart, she quit.

Eight months later, Judd's patients still ask about her. They had a bond. She cared for them, and they trusted her, medical receptionists left behind at the Pryor clinic say. She was as much of a part of the

community as anyone could be.

On a recent spring morning, Judd sits at the dining room table in her house in Billings. Her face is smooth and she has the lean build of a lifelong runner. Her eyes spark when she talks with amusement about her failed attempts to learn the Crow language, then soon well up when talk turns to her Crow goddaughter. As the conversation focuses on her decision to leave Pryor, her eyes become lifeless and dull, much like the overcast skies that hide the sun just outside the nearby window. She still says "we" and "our" when she refers to the small clinic.

And she still talks about "her" patients, though they are no longer hers.



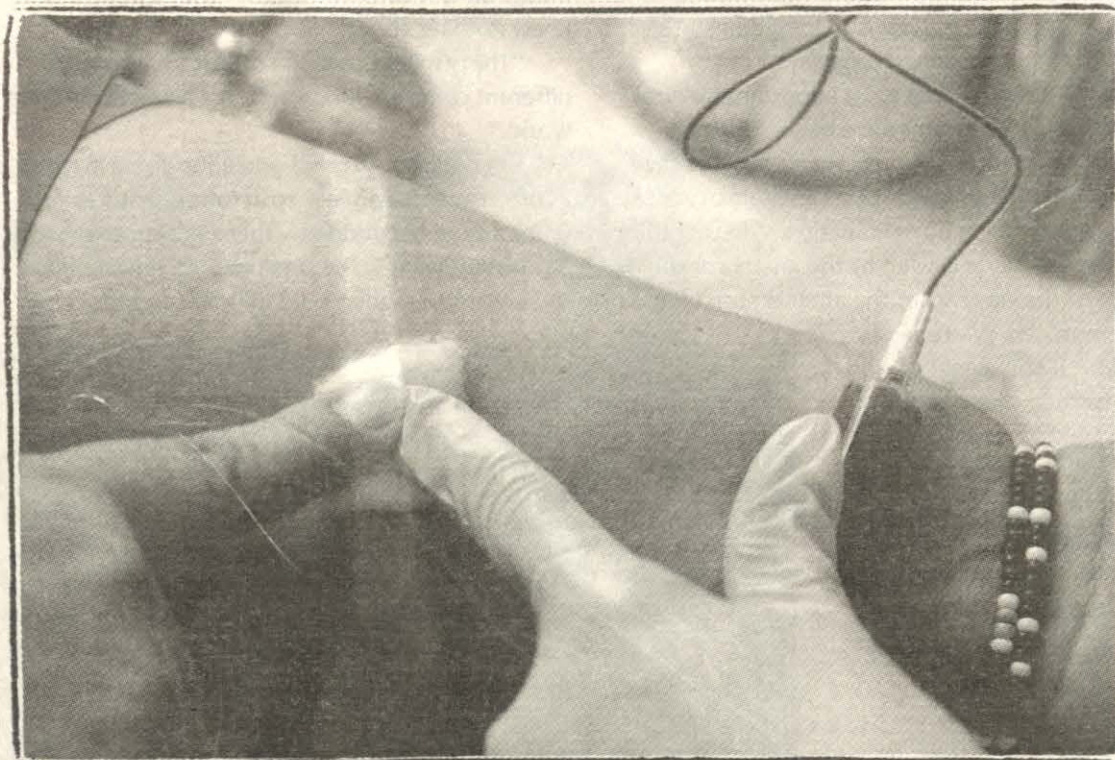
When the Crow/Northern Cheyenne Hospital was completed, hospital administrators asked artists to donate work for the facility. Artwork, such as these pieces by Cyrus Gros Ventre, now decorate the hallways of the hospital.

took at least a full two years before her patients began to trust that she was there to stay, and was there to give them the best treatment possible. Simple things like eye contact from a patient were nonexistent at first. But as she kept showing up, and kept trying to learn about the people she was treating, her patients started to let her into their lives.

They began to share frustrations about the ever-changing cast of doctors at the clinic and how they felt like a forgotten community, a stepchild of Crow Agency. Her patients saw how she fought with the layers of bureaucracy that separate IHS administration from the people on the ground to get better equipment for the clinic and more




Teaching Understanding



*Written by
Tyson Alger*

*Photography by
Brooke Andrus*

FLATHEAD



Population: 26,172
Native: 20%
Counties: Flathead, Lake,
Missoula, Sanders
Reservation center:
Pablo

The first time the
needle pierces the skin, it
immediately hits crimson.

It's 9:15 in the morning at the Tribal Health Clinic in St. Ignatius and nurse Candice Brown draws blood from her first patient of the day.

She grasps the woman's arm with her hand, holding it with the steadiness and precision of a professional but with the care of a relative. As blood slowly fills the vial, Candice engages the woman in small talk.

She recalls the last time the patient came

in, how hard it was to find her veins. The woman counters that she made sure to drink a lot of water before arriving. The conversation moves from the medical to the personal, as Candice inquires about a cousin of the patient's. An enrolled member of the Confederated Salish & Kootenai Tribes on the Flathead Reservation, Candice often is well acquainted with the patients she attends to. As the conversation progresses and the blood nears the top of the vial, a calm has settled over the jittery patient. She chats with ease, the slight nervous stutter that filled her voice before the procedure no longer interrupting.

This talk is crucial to the checkup process at this tribal health center, where staff work to combine

modern medical practices with Native American culture. While the woman is a regular of Candice's, for some first-time patients these initial moments help establish trust and build an important relationship.

"A lot of times if the patient isn't comfortable they won't share things with us," Candice explains later.

Crimson has now completely taken the place of clear and Candice pulls out the needle. The woman winces as Candice finishes, relaxing when a bandage is applied in the crook of her left arm.

As Candice eyes the warm vial through her thin rectangular glasses, the woman looks up at her.

"You got me on the first poke," the patient says cheerfully.

Later, Candice talks of the interaction between nurse and patient. She emphasizes that each must be looked at as an individual. Her goal is to make each patient comfortable, even at times by unconventional means.

"They tell you not to hug your patients," she says, "but there are some times when they are having a hard time and crying. They are my people. They are my cousins... So I've given patients hugs.

"Sometimes that's all they want. They need somebody to tell them that it's going to be OK."

It may seem mundane, but this type of patient-provider interaction on the reservation was almost unheard of 20 years ago. Indian Health Service nurses were primarily white and often had little understanding of their patients' culture and community.

"There were just very few Indian nurses on the reservation," Salish Kootenai College President Joe McDonald says.

White nurses tried their best to accommodate the unfamiliar culture, but seldom saw success. Culture clashes would arise from differences in healing theories—what the provider thought was best for a patient's health might conflict with the patient's traditional values. Tribal customs could complicate even a routine procedure, as a patient's concerned relatives would sometimes crowd the examination room in hopes of offering support and guidance, but sometimes making it harder for medical personnel to do their jobs efficiently.

"When there is a serious illness the whole family will come," McDonald says. "They will all be here. If your uncle is sick, you just drop what you're

doing and you just come."

In these cultural misunderstandings, McDonald saw an opportunity for SKC: to create a nursing program to produce exceptional nurses who specialize in work on Indian reservations.

McDonald explains that establishing the SKC nursing program was no easy task, motioning with the tired right hand of a 74-year-old that has been at the forefront of this Native American college's rise over the last 33 years. He sits in his office in Pablo, looking out to the Mission Mountains. Two blocks from his office is the John Peter Paul Building, home to the college's nursing program.

Securing approval from the state nursing board and funding for the program were challenges, McDonald says. But the biggest obstacle was recruitment. In the early 1990s, few Indians were interested in nursing. And the program lacked the reputation it has today, which made it difficult to attract interested students.

Of the few students who chose to attend

many were not prepared for the strict regimen of the associate of science nursing program. But the college wouldn't budge on the rigors of the classes. In real-world situations, nurses have no time for hesitation. Choices must be decisive. There's no gray area and there's no room for error.

"I would get some complaints early on about students having trouble with the program," McDonald says. "But when you're lying there on a gurney and a nurse is about to put an IV in your arm, you don't want any gray."

Those first students survived and thrived and 19 years later the program is the number one producer of Native American and Alaska Native nurses in the country, according to the college. Today the SKC nursing program boasts close to 150 students.

...

Candice Brown knew from an early age that nursing was her calling. She just wasn't always ▶



ABOVE: Candice Brown stands in front of the St. Ignatius Tribal Health Clinic. Brown graduated from the Salish Kootenai College nursing program in 2009, and is now a full-time registered nurse at the clinic.

OPPOSITE: Brown has a patient apply pressure to her arm to encourage clotting after a routine procedure. The St. Ignatius Tribal Health Clinic serves members of the Confederated Salish and Kootenai tribes.

sure that the dream was within her reach.

As the daughter of a Navajo father and Salish-Kootenai mother, Candice split time between Montana and Northern Arizona. The moves were frequent, and sometimes tough. The toughest test, however, began the day her brother died.

On Dec. 8, 2000, Candice's brother Victor killed himself after years of battling paranoid schizophrenia. His death sent Candice down a dark path. She became secluded and depressed. At school in Arizona she had already been struggling, having trouble making friends. She says other students were part of cliques and ridiculed her. When Victor died, the torment from fellow students didn't stop. Her depression deepened. Teachers didn't help, she says, because they didn't recognize the depth of her pain. To them, Candice was acting out. It became almost unbearable.

"I got to the point where I just didn't want to be here anymore," Candice says as her voice drops slightly. But then she got help. Through the encouragement of her parents, Candice went to counseling. She talked to people about her feelings. She journaled. She researched depression. And she started to get better, eventually conquering her depression and emerging with what she says was a new appreciation for helping others.

"I wanted to get through it so I could do something with my life," she says.

Candice's father, Preston Brown, says he

noticed a change in his daughter after the death of his son.

"She wanted to dedicate herself to knowing how that could have been prevented and the whole subject matter of health services," Preston says from his home in Arizona. "That pretty much gave her an incredible spark because it involved the death of a loved one."

A determined Candice scratched and clawed her way through middle school and part of high school, before deciding to obtain her GED at age 16. She wanted to go to college to become a nurse and help people. She searched for a college that could teach her to how to prevent tragedies like her brother's—one that would teach her to treat patients with both compassion and medicine.

Salish Kootenai College was a perfect match for Candice.

...

It's Tuesday morning in the John Peter Paul Building, and second-year nursing students gather in a lab. It's the first class after a two-week end-of-the-quarter break. The 11 students are noticeably lively, all of them chatting and catching up after the vacation. The room exudes a certain "calm before the storm" quality. The talk is lighthearted and the students are loose, but this is sure to change as June graduation quickly approaches.

The majority of the students are of Indian

descent, a few others are Caucasian and one is black. Lashinda McBride expects to soon be the second black graduate of the SKC associate of science nursing program.

As some of the students continue to talk, she checks up on Meti Man. Meti's skin is tan and rough. With each breath his sculpted chest expands and contracts. Lashinda leans over and grabs his wrist. After looking at her watch, Lashinda says his pulse is 113 beats-per-minute, though that's soon recalibrated to a more-normal 60 beats. Taking her stethoscope from around her neck, she then puts the buds in her ears and places the other end on Meti's stomach to listen for his bowel sounds. She moves it around for several seconds, shrugs, and then takes the buds out of her ears.

"We all know what normal sounds like," Lashinda says. "It's the abnormal sounds we're looking for."

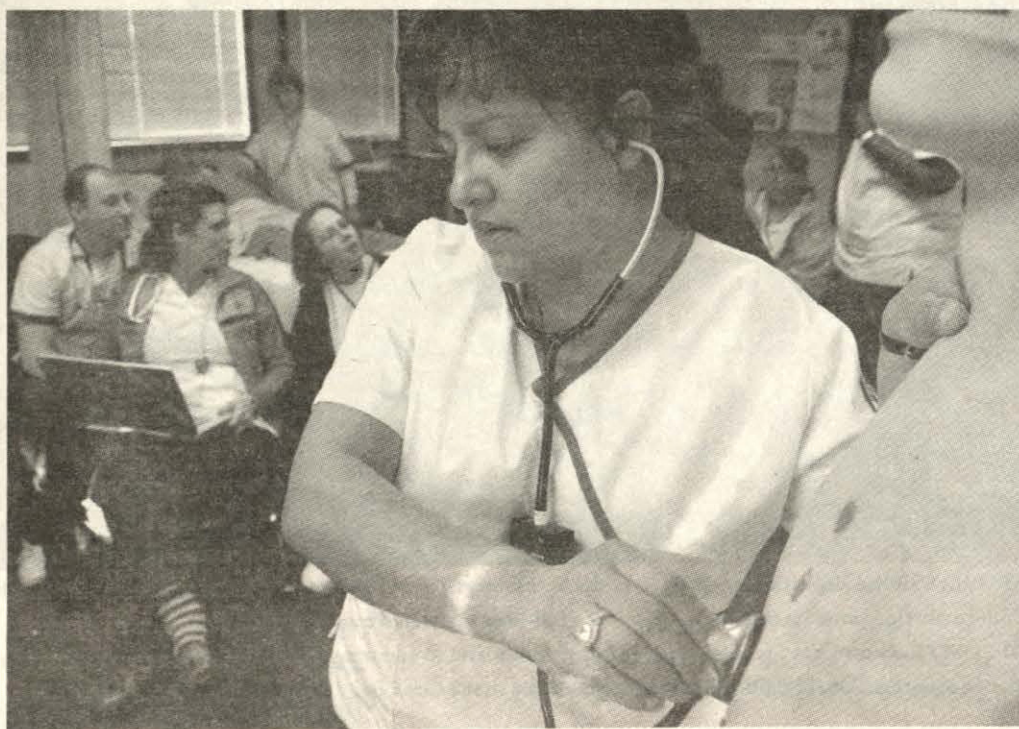
She guesses that nothing is wrong with Meti and says he should be fine. Meti would have breathed a sigh of relief and thanked Lashinda for the prognosis. But Meti can't talk. He's a computer-programmed dummy—one of three high-tech dummies that the SKC nursing program uses to train its students for real-world scenarios. It's only through a combination of modern medical technology and rigorous cultural training that SKC prepares its nurses for the challenges of treating patients in Indian country, where medical resources are limited, cultures diverse, and chronic diseases like diabetes and alcoholism prevalent.

During the rest of the class the students take turns on Meti, along with his buddies Stan and Petie. They are instructed by the teacher what to listen for in the dummies' lungs and bowels, all things they'll do in the real world.

While learning to listen for cardiovascular abnormalities is a necessity for a nursing student, at SKC listening to patients and understanding their traditions and personal concerns is equally important. In other classes, students are taught about diversity, holistic care methods, and Indian culture. Twelve Native American studies credits are required of all students before graduation.

Those are the classes that help Lashinda. A Minnesota transplant who ventured to Montana after 15 years as a certified nursing assistant, Lashinda came out West after hearing about SKC from an eastern Montana relative. A city girl from Minneapolis, Lashinda had never had much

Second-year nursing student Starlite Brewer practices what she has learned on a mechanical dummy in the lab at the Salish Kootenai College. The dummy mimics various heart conditions for the students to diagnose.



interaction with Indians. Learning how to deal with different types of patients is crucial for Lashinda, along with the rest of the class, as studies show that 95 percent of graduates with SKC associate of science nursing degrees will work on a reservation. Lashinda plans to take a job in Deer Lodge.

Lisa Lackner is in charge of making sure each student learns the practical and cultural components of nursing. As the SKC director of nursing, Lackner emphasizes what she calls the four Cs. The first C stands for critical thinking — crucial in emergency situations. Then citizenship and communication follow. The fourth is what Lackner says makes the program unique — cultural competence.

The SKC curriculum is tailored to train nurses to work with Native American cultures, but it also underscores the importance of accommodating patients from any culture. That means talking with patients, asking the right questions and most importantly, listening.

By listening, nurses can learn which specific treatment is appropriate for each patient. If a nurse prescribes a regimen that a patient won't adhere to because of a cultural conflict or misunderstanding, the nurse has done nothing for the patient.

Lackner teaches her students to throw out any preconceived notions about a patient. She instructs nurses to sit down with their patient and develop a plan together — one that improves the patient's health while respecting the patient's values.

"It may not be the ideal treatment plan you have in the back of your head," she says. "But that may only be ideal for your culture."

The majority of SKC graduates are familiar with Indian culture even before they enroll in the program. There is a sense of solidarity among the students, a connection to the community and to Indian traditions. That, combined with a rigorous nursing curriculum, helps SKC achieve its ultimate goal of putting more Indian nurses in Indian health care facilities.

...

Candice doesn't get the leisure time many 22-year-olds do. Monday through Friday she happily works with patients from 9 to 5. Once home in Ronan, she gets to work on further nursing studies. It's been almost a year since she earned her associate's degree, but school is still in her



Brown chats with a patient as she draws blood. Pleased with her experience, the patient tells Candice she did an "awesome job."

system. Now she's taking online courses at home through SKC in its bachelor's of science nursing program. She's looking further down the road to the possibility of a master's degree.

That could come from SKC if things fall into place. Due to budgetary and building deficiencies, McDonald says the school can't yet field a master's program, but would like to eventually. Currently the nursing department shares the same roof as the SKC dental program, which occupies the first floor.

With a master's or doctorate, Candice would shift from dealing with individual patients as she does now to becoming someone who works on nagging medical problems prevalent on the reservation. These range from the diabetes that runs rampant on the reservation, to alcoholism and prescription drug abuse.

Statistics show what Candice sees every day in the tribal health center: An American Indian is twice as likely to be diagnosed with diabetes as a non-Indian, according to the U.S. Department of Health and Human Services. One in nine American Indian deaths is alcohol-related. And prescription drug abuse is a growing problem on Indian reservations.

But for Candice, these aren't just statistics. They're people she went to school with, people from her community. Every day, every patient who walks into the examination room brings her a step closer to her goal — an ambitious goal to be sure. Before she gets there, she has a lot more listening to do and a lot more learning.

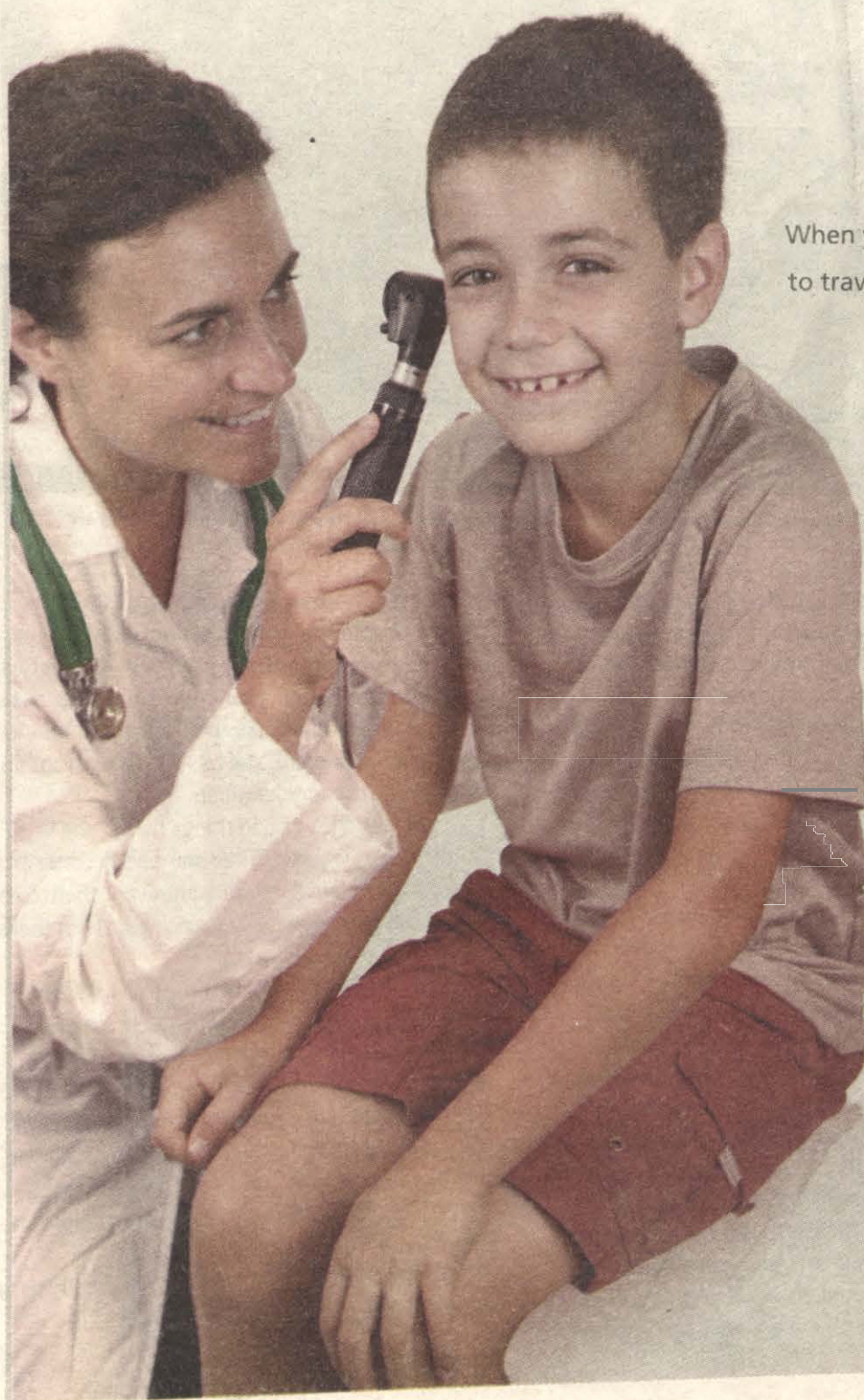
"You see a lot of bad things here," she says. "But the days when you see somebody come in and their blood sugars are where you want them to be... it just feels great. Because you've got them there. You helped them get there."

Back in her office, Candice looks up at the clock, awaiting her 2 p.m. patient. He's running a few minutes late, but she hears the shuffling in the hallway and quickly rises to greet him. The two exchange greetings as he walks into the examination room. Before entering, Candice reaches up and pulls a small yellow lever on the wall that sticks out like a flag. This tag lets people know the nurse is with her patient.

She enters the room with a smile, ready to talk, and ready to listen.



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